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The Rules of Civility

FRANCIS E. WEST, M.D., San Diego

BACK IN THE YEAR 1748, a young man 16 years of age was concentrating on the writing of his own ideas of the "Rules of Civility."

This was a common practice in those days and dated back to the year 1595 when the French Jesuits set forth a list of important objectives in human relationships and deportment.

Today it might be called "How To Win Friends and Influence People." The logic is the same, although the language and terminology then was perhaps more lofty than is used in our current conversations and communications.

I was struck by this rule the young man had inscribed:

"In visiting the sick, do not presently play the physician if you be not knowing therein."

Thirty years later, the boy, then a man of 46, found himself at Valley Forge, the winter headquarters of the ragged, tired, weary and hungry soldiers of the Revolutionary Army. Those stalwarts numbered a scant 11,000 men.

Their leader, the man who had served his own conscience and his fellow patriots for the past three years without one cent of pay, of course, was General George Washington.

Every American knows how, from the depth of despair at Valley Forge, Washington's prayers were answered and he went on to set the Colonies free; that the final peace treaty with England made possible our United States of America.

Our many freedoms, our many rights, the democracy we enjoy today result from the hardships and the suffering and the sacrifices and the determination of George Washington and his 11,000 men.

Here today we meet in free assemblage to speak our minds.

Day in and day out we practice our profession with a freedom circumscribed only by our own rules of civility—our ethics.

Where, in matters of setting standards of qualifications and education of our fellow practitioners, we have found it necessary for governmental regulation, we, the members of the profession, have pressed for that necessary legislation for the protection of our patients against the incompetent, the charlatan and the quack.

The members of the House of Delegates of the California Medical Association represent 17,000 American physicians. Think of it—6,000 more than Washington's entire Army at Valley Forge.

I believe it most fitting, therefore, that before we embark upon the matters before this free and unfettered gathering we pause for a moment to express our reverence to the great man whose 227th birth date anniversary we celebrate today.

Now for the convention affairs at hand.

It has been two years since I was named your President-Elect and assumed the presidency one year later.

During that time it has been my great pleasure to have visited all the county societies, many of the districts and to have attended meetings of specialty groups and to have consulted with officers of the

Address of the President, presented before the Annual Meeting of the House of Delegates of the California Medical Association, February 22, 1959, San Francisco.

Bar and members of the California Hospital Association.

I leave the office with certain feelings of nostalgia because of the fine people I have met and the friends I have made.

To be sure, I have suffered some pangs during my term in office.

On the other hand, your C.M.A. has not been without its accomplishments in the over-all field of medical care for all the people of California.

These accomplishments, to be sure, have largely been the results of the efforts of the highly respected and capable men you have elected to office. I mean my colleagues on the Council who, in turn, have chosen wisely in naming the physician-members of the commissions and committees that have been doing the hard, grinding, time-consuming work of the California Medical Association since the last meeting of this House.

Here, I believe, is an opportune time to name two very important gentlemen who will loom large in the immediate future of C.M.A.

First, there is Dr. T. Eric Reynolds who, on Wednesday, will assume the presidency.

Be assured your affairs will be in good hands.

Eric Reynolds, I have found, is as capable as he is quiet and mild-mannered. And during 1959 you will learn what I already know—that he is a man of sound judgment backed by many years of experience as a practicing physician and in service to his own Alameda-Contra Costa Medical Society and C.M.A.

Next, the report of the Legal Counsel, Peart, Baraty and Hassard, following custom of long standing, will be made by Mr. Howard Hassard. But this year, Mr. Hassard comes before you as *both* our legal counsel *and* our newly appointed Executive Director, named by the Council to direct the internal affairs of C.M.A. I am distinctly proud to make this announcement at this time.

Hap Hassard and his firm, dating back to the days of the dearly beloved Hartley Peart, have served C.M.A. for the past 41 years. He, better than anyone else, knows *all* the workings of our Association. His influence for good has already been felt.

He has our every best wish and our united promise of the utmost of cooperation in the years ahead.

At the close of one's term—reaching the apogee of one's career in the official orbit of the Association—there is, of course, the temptation to "preach"—to prescribe "rules of conduct"—to cut a pattern to be followed in the future—to assume the role of the "elder statesman."

On sober contemplation, however, on taking inventory of my capabilities, it would be presumptuous to address you in such a tone today.

Sober judgment, coupled with hard practicality, makes me realize that, in today's fast-moving world, edicts, warnings, elder statesmanship, predictions are of doubtful value.

And besides—who wants to be considered old?

In addition to those topics I have already mentioned, here then, are some things I *do* know about and can report to you:

For instance, C.M.A. will soon be headquartered in its own new building where our constantly increasing membership can be better served by a staff which, of necessity, has been enlarged to keep pace with our growth.

As to our relations with state and federal bodies, I can only state that, in my opinion, our performance record has merited a mark of "good." Not excellence, perhaps, but "good."

Collectively we can drop to "fair" or to "poor," or we can approach "excellent" in direct proportion to the measure in which we follow Dr. Malcolm Watts' motto on the masthead of our Public Relations Department *Newsletter*. It reads:

> *"What is best for the patient is always best for medical practice and for the doctor."*

California's esteemed Dr. Dwight H. Murray has translated the same statement legislatively in his straightforward declaration that:

> *"Satisfied patients always have been and always will be our first line of defense against government domination of our profession."*

It has been my experience that when we bring these two fundamentals with us into our discussions with all groups—and that includes discussions *within* the profession; when we stand by these principles—we are understood and we are respected.

Understanding is often slow—difficult to achieve. However, once fully understood in our position of concern for patients, we then can expect to earn respect.

The profession is at its best—is understood and believed—when it is concerning itself with matters medical be they in the realm of politics, care for certain segments of our population designated by the elected representatives of the voters, or in the field of voluntary, prepaid medical and hospital insurance.

"General" Dwight Murray can tell you about a mere 7,000 physicians holding the line against Governor Warren and an entire administration's attempt to socialize our profession; how his "tired and weary" physician-soldiers staged a winning battle against medical oppression.

That was 14 years ago, back in 1945.

Members of the legislature believed the physicians' arguments; that the medical profession, the Blue Plans and the private insurance carriers, not

politicians, could best provide medical care insurance for the people of California.

More recently in our negotiations with State Welfare Department officials, the profession prevailed in removing prior authorizations in the care of the aged because we proved that we could be trusted to decide how best to treat our patients.

Likewise, the growth of voluntary health insurance plans attests the public's faith in the profession's knowledge and sincerity in this ever-expanding field.

We can maintain our reputation, our integrity, so long as we meet our expected duties, our self proclaimed responsibilities.

These duties and responsibilities are seemingly small matters to physicians who uphold them every day in their practices and to county societies that insist upon their implementation.

They include the provision of medical care for all regardless of inability to pay.

They include the provision of emergency care on a 24-hour basis.

And they further include the operation of Public Service committees where misunderstandings between physician and patient can be resolved.

Truly, my greatest concern for the future of medicine stems back to the necessity for our constant vigilance to see that these three important promises to patients, to voters are kept.

Once we lose sight of the truths of the Murrays and the Watts' we fail in our duties as individual physicians. Collectively, the profession is then headed for serious troubles. In even simpler words:

> Any regimentation, in my opinion, will not stem from *without.* It can come, however, from a lack of self-discipline and meeting up to our responsibilities *within* the profession.

I mentioned the year 1945 and our 7,000 doctors to emphasize our great growth both in population generally and in the number of physicians. In a manner of speaking we are a new state. We are new in the sense that we've long since made the transition from agriculture to commerce. Much of our population is new! Our physician population has more than doubled in recent years.

But our responsibilities to our patients; the responsibilities of the older physician and the new one to the population, *both old and new,* remain the same. And all residents over the age of 21, may I emphasize, have an *equal* vote.

As members of the House of Delegates of the California Medical Association, the elected representatives of your constituent societies, *you* must assume the responsibility to be ever watchful to see that our standards are maintained and our promises to the public are remembered and fulfilled.

Just what is the California Medical Association?

The booklet sent out to new members of the C.M.A. by Mr. John Hunton states:

"C.M.A. is actually a federation of county medical societies, 40 of them located in all parts of California. Its membership is made up of the combined memberships of the county societies—it has no members except the county society members."

This, then, means to me that C.M.A. encompasses the young general practitioner just starting his practice in Chula Vista or Eureka, the specialists on Sutter and Post streets in San Francisco and on Wilshire Boulevard or in Beverly Hills in the Los Angeles area.

It means the physician in public health, the professor at one of our five fine medical schools, the deans, the researcher, the young resident and our semi-retired elder colleagues. And the new men coming from other states to take up practice in California.

These are the men and women who make up our Association, the second largest—and soon to be the largest—medical Association in America.

You are the men who represent them. . . . All of them.

While you—while we—are gathered here to conduct the organizational phase of our federation of the 40 county societies, an even greater number of our confreres are assembled in meetings throughout the city, conducting or attending scientific phases of our convention.

Present here too are the gentlemen of the press who are here to report the deliberations of this meeting as well as the progress on the research and the scientific side of our profession.

These members of the Fourth Estate are here to report what they hear and see.

Their reports go out all over the state and nation to their readers—the voters—our patients.

I can only hope that what they hear and see in both forums will be constructive; in this assembly for the care of the business of the Association, but, more important, in the assemblies where we are disseminating the knowledge of the progress we are making in the care of our patients.

One final word: I thank you all for the confidence you showed in me when you elected me to office two years ago. It has been a high privilege and a great honor to serve you. I can only hope that I have, in some small measure, lived up to your confidence and to that honor.

There is but one other thing:

As young George came near the close of his "Rules of Civility," he wrote:

> *"Undertake not what you cannot perform, and be careful to keep your promises!"*

2850 Sixth Avenue, San Diego 3.

Tetanus in California

Epidemiology and a Review of 232 Cases

PHILIP K. CONDIT, M.D., Berkeley

• A study was made of records of the 232 reported cases of tetanus in California, from 1953 through 1958. Cases occurred in 30 of California's 58 counties. Two-thirds of the patients lived in suburban and urban areas. Two-thirds of the cases occurred in persons over the age of 20 years. The incidence was twice as high in males as in females. Forty-seven per cent of the patients died, with the highest death rates being in persons over the age of 40 years.

Sixty-three per cent of the injuries associated with these 232 cases occurred in the home environment and 17 per cent at the place of employment.

Ninety-one per cent of the patients had never been immunized with tetanus toxoid, or if they had been immunized, had not received the booster injections necessary to maintain effective immunity. Nine per cent gave a history of having had one or more injections of tetanus toxoid within five years.

TETANUS SINCE ANCIENT TIMES has been a much feared, agonizing and highly lethal disease. In recent times medical science has provided effective means for its prevention. Yet in California from 1920 through 1958 there were reported 2,383 cases of tetanus with 1,381 deaths, a mortality rate of 58 per cent.

The purpose of this report is to review certain aspects of recent experience with this disease and stress the importance of wider use of tetanus toxoid for active immunization.

For the period 1953 through 1958 information was collected by the State Department of Public Health, with the cooperation of practicing physicians and local health officers, concerning 232 cases of tetanus. This information, collected for each reported case, on a form entitled "Epidemiologic Case History of Tetanus" has provided the material for this report.

Cases of tetanus have been reported from 30 of California's 58 counties during the past six years (Table 1). One hundred and ten cases occurred in Los Angeles County. The remaining 122 cases were widely scattered: 17 were in Orange County, 12 each in San Bernardino and San Diego counties, 10 in Fresno, 8 in Alameda and 7 or fewer in each of the remaining 24 counties.

Table 2 shows the number of cases reported, the number of deaths and the mortality rate. Although considerably lower than the mortality rate of 82 per cent for the period 1920 through 1924,[1] the rate of 47 per cent for the years 1953 through 1958 was still extremely high.

Who gets tetanus and in what circumstances? Previous reports from other parts of the nation have indicated that tetanus occurs most frequently among inhabitants of rural areas. In this series, however, approximately two thirds of the patients lived in cities, suburban areas and towns. Farm workers who had the disease were outnumbered by skilled

From the Division of Preventive Medical Services, California State Department of Public Health, Berkeley 5.

Assistant Chief, Bureau of Acute Communicable Diseases, California State Department of Public Health, Berkeley 5.

Technical assistance in the preparation of this report was provided by Geraldine B. Edwards, M.P.H., Public Health Analyst, California State Department of Public Health, Berkeley 5.

Presented before the Section on Public Health at the 88th Annual Session of the California Medical Association, San Francisco, February 22 to 25, 1959.

TABLE 1.—*Tetanus in California by County of Occurrence (1953-1958)*

County	Cases	County	Cases
Alameda	8	San Bernardino	12
Butte	1	San Diego	12
Contra Costa	3	San Francisco	1
Fresno	10	San Joaquin	6
Humboldt	4	San Luis Obispo	2
Imperial	1	Santa Clara	5
Kern	7	Santa Cruz	2
Los Angeles	110	Solano	1
Marin	3	Sonoma	2
Merced	1	Stanislaus	2
Monterey	1	Sutter	1
Orange	17	Trinity	1
Placer	1	Tulare	3
Riverside	5	Ventura	5
Sacramento	1	Yolo	1

TABLE 2.—*Tetanus Cases and Deaths in California, 1920-24 and 1953-58 by Year*

Year	Cases	Deaths	Per Cent of Cases Dying
1920-24	264	216	82
1953	42	18	43
1954	47	23	49
1955	34	16	47
1956	34	14	41
1957	32	16	50
1958	43	22	51
Total 1953-58	232	109	47

and unskilled industrial workers by a ratio of approximately three to one.

Tetanus occurs in both sexes and in all age groups. Two-thirds of the cases reported upon herein occurred in adults. There were 160 cases in males and 72 in females, a ratio of 2.2 to one. The death rate was higher in females (53 per cent) than in males (44 per cent).

The two youngest patients were 17 and 21 days old; each had an infection of the umbilical cord stump. The two oldest patients were an 81-year-old housewife whose foot was punctured by a nail while she was walking in a chickenyard at the rear of her home, and an 81-year-old man whose thumb was lacerated while he was cutting old lumber with a power saw at his home.

When considered by ten-year age groups, children under the age of ten years were the most frequent victims of tetanus; they made up 21 per cent of the total number of patients (Table 3). Tetanus occurred least frequently in young adults 20 to 29 years old; 7 per cent of the cases were in that bracket. However, a considerable proportion of the cases occurred in each ten-year age group from the very young to the very old.

It has been pointed out elsewhere[2] that in tetanus the age of the patient has a definite relationship to the survival rate. Fifty-three per cent of the 232 patients in the present series recovered (Table 3). The highest survival rate, 79 per cent, was in patients in the 10 through 19 age group. The poorest recovery rate, 23 per cent, was in the 70 through 79 age group; and the rates were substantially lower in all age groups over 40 years.

Seventy-eight per cent of the cases and 68 per cent of the deaths in this series occurred in connection with minor injuries (Table 4). The public traditionally associates minor puncture wounds (stepping on a rusty nail) with tetanus. Slightly less than one-third (31 per cent) of the 232 cases reviewed here were associated with minor puncture wounds from nails, slivers, thorns or other sharp objects. Of the 182 cases in the minor injury group, 39 per cent were associated with puncture wounds and 61 per cent with other types of injuries. Twenty-one per cent were associated with lacerations, 16 per cent with abrasions and 8 per cent with crushing injuries to fingers or toes. The remaining 16 per cent were associated with minor lesions and injuries of various types, including burns, blisters, ulcers and ingrown toenails.

In the major injury group tetanus was associated most frequently with lacerations and compound fractures. Gangrenous lesions, abortions, burns, bullet or knife wounds, major surgical procedures and crushing injuries were each associated with five cases or fewer.

Sixty-three per cent of the injuries in the 232 cases occurred in the home environment (Table 5).

TABLE 3.—*Tetanus in California, 1953-1958; Reported Cases by Age Group—Fatality and Survival*

Age Group	Number Cases	Number Recovered	Number Died	Per Cent of Total	
				Died	Recovered
All ages	232	123	109	47.0	53.0
0 to 9	49	32	17	34.7	65.3
10 to 19	34	27	7	20.6	79.4
20 to 29	16	10	6	37.5	62.5
30 to 39	19	12	7	36.8	63.2
40 to 49	37	16	21	56.7	43.3
50 to 59	25	8	17	68.0	32.0
60 to 69	32	14	18	56.2	43.8
70 to 79	17	4	13	76.5	23.5
80+	3	....	3	All	....

TABLE 4.—*Tetanus in California; Cases and Deaths by Type of Injury 1953-58*

MINOR INJURIES			MAJOR INJURIES		
Type of Injury	Cases	Deaths	Type of Injury	Cases	Deaths
Total	182	74	Total	46	35
Punctures:			Compound Fractures:		
Nail	28	14	Highway accident	4	4
Slivers	25	11	Other	8	6
Other	19	9	Lacerations	15	12
Lacerations	38	16	Gangrene:		
Abrasions	30	11	Diabetic	2	2
Crushed finger or toe	16	5	Other	3	3
Blisters	4	....	Surgery (major)	3	2
Ulcers	4	....	Burns (severe)	3	2
Burns (minor)	2	....	Abortion	4	4
Infections:			Bullet or knife (puncture wound)	3	....
Ingrown toe nails	6	3	Crushed foot	1	....
Umbilical cord	2	1			
Infected ear	1	....	No known injury	4	....
Infected gums	1	1			
Infected insect bite	1	1			
Tooth extraction	1	....			
Other minor surgery	4	2			

TABLE 5.—*Tetanus Cases by Place of Injury; California, 1953-58*

Place	No. of Cases	Per Cent
Total	232	100
Home and yard	145	63
At work	39	17
Highway accident	6	2.2
Other	34	14.5
Unknown	8	3.3

Seventeen per cent occured at the place of employment, 2.2 per cent were received in highway accidents and 14.5 per cent occurred in a variety of other places including the public streets and sidewalks, public parks and playgrounds, abortionists' "offices," vacant lots, a night club and a cow pasture.

Ninety-one per cent of the 208 patients for whom information on this subject was obtained had either never been immunized with tetanus toxoid or had been inadequately immunized[5] in the sense that the last injection of tetanus toxoid had been received more than five years before the injury (Table 6). Nine per cent gave a history of having been immunized within five years. However, detailed information was not obtained with reference to the exact dates of immunization and the number of injections. Immunization histories are not always reliable. People often recall with difficulty and inaccurately information concerning what "shots" they or other members of their family have had and when they were received. In one case, for example, a child lacerated an arm in a fall in the street. A responsible adult in the family informed the attending physician that the child had received the usual immunizations for tetanus, diphtheria and pertussis in the city where the family had formerly lived. On the basis of this information the physician administered a booster injection of tetanus toxoid but did not give antitoxin. Some days later tetanus developed and the child died. Subsequent inquiry revealed that there were nine children in the family and while the records showed that some of them had been immunized, this particular child had not. It is probable that if complete and accurate information concerning their immunization history could could be obtained, some of the 19 patients listed in Table 6 as having had immunization within five years, would be moved over to the category of "inadequately immunized" or "no immunization." Some of them, however, would probably have had low levels of antitoxin simply because they responded poorly to the antigenic stimulus of the vaccine.

The data in Table 6 are in agreement with previous studies in the Armed Forces[4] in which the high degree of effectiveness of active immunization with tetanus toxoid as a preventive measure is well documented.

Twenty-four (12 per cent) of the 196 patients

TABLE 6.—*Tetanus in California, 1953-1958; History of Active Immunization with Tetanus Toxoid Before Injury in 208 Cases*

	No Immunization	Over 5 Years Ago	Within 5 Years	Total
Cases	166	23	19	208
Per cent	80	11	9	100

TABLE 7.—*Tetanus in California, 1953-1958; Use of Antitoxin Prophylactically After Injury But Before Onset of Symptoms*

Amount of Antitoxin	No. of Cases	Recovered	Died
None	196	107	89
1,500 units	20	9	11
3,000 units	3	2	1
4,500 units	1	....	1

TABLE 8.—*Tetanus in California, 1953-58; Results in 203 Cases in Which Antitoxin Was Used for Therapy After Onset of Symptoms*

Antitoxin (1,000 Units)	Total	Recovered	Died
	203	110	93
Under 50	22	12	10
50 to 99	25	19	6
100 to 149	27	14	13
150 to 199	55	25	30
200 to 249	48	25	23
250 to 299	8	5	3
300 and over	18	10	8

for whom information was provided on this point, received a prophylactic injection of antitoxin at the time of the injury (Table 7). Twenty of these received the usual dose of 1,500 units. While the number of cases is too small to be statistically significant, the 55 per cent mortality rate in this group lends support to investigators who advocate 3,000 units of antitoxin as the minimum prophylactic dose.

An important point is that approximately 65 per cent of the patients in this series did not report to a physician until the onset of clinical symptoms of tetanus. The usual reason for delay was that the initial injury or lesion was considered to be of a trivial nature, requiring only home remedies. For these persons the prophylactic administration of antitoxin was of course not possible.

Data are provided in Table 8 concerning the use of antitoxin therapeutically in 203 cases. It is beyond the scope of this report to discuss the treatment of tetanus but this information is included in tabular form because it is relevant to the general subject.

DISCUSSION

Tetanus is a disease that is only partially controlled, even though basic knowledge would appear to allow successful control.[3] The causative organism is a natural inhabitant of the intestinal tract of man and animals so constant reseeding of these organisms occurs in man's environment. Hence, contamination of man's frequent wounds makes each of us a

candidate for the possible development of this disease.[2] Universal immunization with tetanus toxoid provides the potential means of protection. In this respect the occurrence of tetanus can be considered to be the result of what has been termed "unassimilated progress." An effective vaccine is available but it has not thus far been used on the broad scale that would appear to be desirable for the protection of the civilian population.

Active immunization with tetanus toxoid has become a routine part of pediatric practice. However, since a majority of the cases occur in the adult population, immunization should become, to a larger extent than at present, a routine part of medical practice for all age groups. A continuing effort is needed to inform the public concerning the availability and protective value of active immunization. Coordinated effort by medical and public health workers, for the purpose of achieving the highest possible levels of community immunization against tetanus offer, in the present state of our knowledge, the best hope for the prevention and control of this disease.

2151 Berkeley Way, Berkeley 5.

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Discussion by* DONALD E. ROSS, *M.D., Los Angeles

Tetanus is indeed a dreadful disease which has impact on the populace and physicians alike. The great tragedy is that the disease could have been virtually stamped out by a program of universal inoculation with toxoid.

Until we have reached this ideal we still are faced with the problem of treating tetanus-prone wounds and of administering tetanus antitoxin with all of its inherent dangers. Certain points may be briefly stressed:

1. The problem constitutes a serious medico-legal hazard.

2. Thorough cleansing and adequate care of the wound should be emphasized.

3. It has been found that the incidence of tetanus is higher when only 1,500 units of antitoxin are used for prophylaxis than when the dose is 3,000 to 5,000 units.

4. When a highly sensitive patient is encountered it is important to (a) Inquire into the history of allergic reaction, and (b) Let the patient know the dangers.

5. Giving a dose of toxoid to a patient who has not been immunized previously with toxoid is without value.

6. It is now well known that the administration of antitoxin is not as effective in a highly sensitive patient as it is in one not so sensitive.

7. The foregoing shortcomings have led the profession into other fields of research:

(a) Antibiotics of the tetracycline group have been found effective for the prevention of tetanus in animal experimentation. This has not been satisfactorily proven for humans. Evidence is accumulating, however, which gives promise that this group of antibiotics will be effective.

(b) The Cutter Laboratories have prepared a Hyper-Tet gamma globulin fraction from humans who have been hyper-immunized with tetanus toxoid. This preparation would not cause allergic disease or serum sickness.

(c) Transfusions of blood from toxoid-immunized persons are believed to be of value in the treatment of tetanus in highly sensitive patients.

Tetanus

Prophylaxis and Treatment of the Disease

DONALD E. ROSS, M.D., and J. J. KRAUT, M.D., Los Angeles

TETANUS IS SO HORRIBLE and terrifying a disease that the force of its impact is felt by the public and the medical profession alike.

Many phases of our understanding of tetanus are still controversial. One purpose of this article is to help clear the atmosphere and bring about a better understanding of prophylaxis and treatment of the disease. It is hoped also to stimulate physicians to urge public awareness that widespread inoculation with tetanus toxoid is a matter of great importance. The following data state the case cogently:

In California[10] from 1920 to 1954 there were 2,240 cases of tetanus in humans; 1,313 of the persons who had it died.

Tetanus developed in only one of 160,254 persons wounded in battle during World War II.[9] (A tetanus toxoid immunization program for all members of the armed forces was meticulously carried out.)

• **Cleansing and debridement is paramount in dealing with tetanus-prone wounds (severe crushing injuries, piercing wounds, blisters and burns are outstanding examples, particularly if contaminated with dirt, grass or other debris).**

Prophylaxis then is relatively easy in persons who have been actively immunized by toxoid injections. For them, a "booster" injection is indicated.

Use of antitoxin, however, is hazardous, whether for prophylaxis or for treatment of the disease. Since it may in itself cause severe disease, including anaphylactic reaction and serum sickness, decision to use it must be weighed against the possibility of the development of tetanus in each case.

To prepare for use of it, careful history should be taken, with particular reference to sensitivity to horse dander. Dermal tests, and perhaps ophthalmic tests, for sensitivity to the serum should be carried out. Even the tests may be hazardous and precautions should be taken accordingly.

If it is decided that the use of antitoxin is necessary even though the patient is sensitive to the material, desensitization must be carried out promptly, with adequate preparation for severe reaction.

There is experimental evidence that antibiotics of the tetracycline group, given soon after injury, may have prophylactic effect against tetanus.

BACTERIOLOGY AND PHYSIOPATHOLOGY

Clostridium tetani is a spore-bearing anaerobic bacillus. It is present in the intestinal tract of a large proportion of horses and cattle. About 5 per cent of all humans are carriers, but the proportion reaches 20 to 30 per cent among persons who are in close contact with animals.

In almost all cases of the disease the infection remains localized in the wound of entrance, although in rare cases the causative bacteria have been found in lymph nodes. Rarely does the organism enter the circulating blood.

The method of transport and action of the toxin is still a controversial subject. In 1903 Meyer and Ransome[11] concluded from their investigations that the toxin acted directly on the central nervous system, reaching it by way of the regional nerve trunks and spreading upward along the neural pathways in the spinal cord itself. Abel[1] conceded that the toxin may act locally on regional nerves and cause spasms of the muscles supplied by the affected nerves but contended that the toxin is distributed by absorption into the circulating blood.

The action of the toxin in selectively blocking inhibitory synapses in the central nervous system appears adequate to explain the phenomena of tetanus. Excitory impulses multiply and run through reflex pathways unchecked and uncoordinated to produce the muscular spasms so characteristic of the disease.

Submitted January 12, 1959.

From the Ross-Loos Medical Group, Los Angeles 17.

TETANUS-PRONE WOUNDS

Severe crushing injuries and compound fractures are outstanding examples of tetanus-prone wounds. This is particularly true if they are contaminated with dirt, grass and other debris. Often the organism develops in penetrating wounds, most frequently of all in wounds made by splinters; but even minor injuries such as blisters or pricks from rose thorns or needles are also frequent causes. Any burned surface is dangerous, for the bacillus of tetanus may be harbored under the blisters or encrustation.

Early and thorough treatment of the wound is most essential. No amount of antitoxin will prevent tetanus if dead tissue and foreign substances are

permitted to remain deep in the tissues. Wounds should be washed thoroughly with soap and water and copiously irrigated with saline solution. Penetrating wounds should be uncapped by removal of the superficial skin. Some wounds may be excised. All should be opened wide to facilitate removal of all dead tissues, blood clots and foreign bodies. If bone, tendons, vessels or nerves are exposed, they must be covered by sliding the skin over the wound or by skin grafting. Debridement and cleansing in these cases must be particularly meticulous.

PROPHYLAXIS AGAINST TETANUS

The ideal prophylaxis against tetanus is active immunity brought about by injections of toxoid and sustained by periodic injections. Passive immunization—that is, the immunization or prophylaxis that is hoped for when antitoxin is given—entails considerable hazard and should be used only in situations of calculated risk. In some cases it might have to be foregone if the risk is too great.

The incidence of reactions to toxoid is 0.0237 per cent. Delayed serum sickness reactions to antitoxin occur in 30 to 40 per cent of patients.

Active Immunization

Active immunization is accomplished by giving three tetanus toxoid injections of 0.5 cc. each, the second injection to be given 30 days after the first, and the third six months after the second.

To be effective, the course of toxoid inoculations must have been completed at least 30 days before the occurrence of the wound. Toxoid given at the time of injury to a patient who has not had a toxoid series of inoculations is without value. In no such circumstances can toxoid be a substitute for antitoxin.

Active immunization is particularly important for persons who are so sensitive to horse dander that contact brings on a severe asthma attack, because giving antitoxin to such a person, should the need occur, might be dangerous.

Basic immunity produced by a series of inoculations of toxoid declines with the passing of time. It is necessary, therefore, to give a booster injection every four to five years. It is interesting that following these subsequent doses, the blood antitoxin increases to a higher level than that produced by the primary two or three doses of toxoid.

The duration of the immunity so produced is unknown, but there is a growing conviction that it may last eight to ten years or even longer.

It should be borne in mind when treating a tetanus-prone wound that even naturally acquired immunity following recovery from an attack of tetanus is not lasting. Further, a prophylactic dose of tetanus antitoxin produces no lasting immunizing effect.

For children a trivalent vaccine—Diphtheria-Pertussis-Tetanus (DPT)—is recommended for the first five years of life; then the bivalent diphtheria-tetanus (regular) vaccine for ages six to eleven years and the diphtheria-tetanus (adult) vaccine for persons twelve years of age and over, with a booster injection every five years. Parents—and children, too, when old enough to remember—should be made aware that injections of toxoid are being given, should be firmly informed that booster doses are necessary and should be impressed with the importance of being able to inform another physician, should occasion arise, not only that immunization has been carried out but the date of the last booster.

The occurrence of tetanus in infants is alarming. In one recent year more than one-third of all deaths from tetanus in the United States occurred in patients less than one year of age. Immunization of the prospective mothers by toxoid would give a measure of protection to the newborn infant. Significant levels of antitoxin have been demonstrated in infants whose mothers previously received toxoid.[14]

Passive Immunization

Since there is risk associated with the administration of a prophylactic dose of tetanus antitoxin, it is important to determine which wounds are such as to make the prophylactic use of antitoxin advisable. Obviously in the more serious cases antitoxin is almost mandatory, assuming, of course, that there has been no active immunization. The great problems are small wounds. The decision must be the physician's to make. In general, he may decide to withhold antitoxin in the case of a superficial wound that can be excised or adequately cleansed. If he decides that antitoxin is necessary, he should fully acquaint the patient with all the difficulties and risks of complications.

Dosage of Antitoxin in Prophylaxis. The usual dose of antitoxin given in prophylaxis has been 1,500 units. There is a distinct trend toward larger doses. Now 3,000 to 5,000 units is more generally acceptable. Many investigators now believe that in dealing with a patient who has a very severe, mutilating injury, a dose of 10,000 units or more is suitable. Using continuing doses of antitoxin daily or every other day until the danger is over is not considered proper for prophylaxis, since sensitization increases with each subsequent dose and tetanus would be more difficult to treat if it should occur.

Should a tetanus-prone wound be encountered several days after its occurrence, it still may not be too late for antitoxin, but a much larger dose of it—10,000 units at least—should be given.

Prevention of Reactions to Antitoxin

(a) *History of Allergic Tendencies.* It is essential to inquire carefully as to history of possible allergic sensitivity before giving any antitoxin. Most im-

portant is a history of asthma precipitated by contact with horse dander, for it is probable that the subject is highly sensitive to horse serum in any form and that administering antitoxin to him might be virtually impossible.

(b) *Tests for Sensitivity and for Reaction.* Before giving antitoxin, a test for sensitivity must be done. For this, an intradermal test and sometimes an ophthalmic test may be carried out.

For the average physician the intradermal test is the most practical. It is performed by injecting 0.02 cc. of 1:10 dilution of antitoxin intradermally. Using precisely that amount is important, for "readings" of reaction are unreliable otherwise. The same amount of normal saline solution is injected into the other arm as a control. The site of injection is kept under close observation for 15 to 20 minutes and if no local or constitutional reaction occurs, the result is "negative" and the required amount of antitoxin may be given subcutaneously with little fear of serious reaction.

Many authorities[2] believe that the ophthalmic test has a definite place in dealing with patients with a history of allergic disease. If the skin test for sensitivity to antitoxin is negative but there is history suspicious of allergic disease, the ophthalmic test is advisable. If the reaction to it is positive, it is a warning that any desensitization process or the administration of antitoxin may be hazardous.

The test is done by placing one minim of diluted horse serum (1:10 or 1:100) in the lower conjunctival sac of one eye and one minim of normal saline solution in the other. Lacrimation, redness and itching following the instillation of the horse serum, appearing immediately or 15 to 20 minutes later, are "positive" results; the absence of any of these manifestations is "negative."

The ophthalmic test is not without risk. Severe reaction may cause corneal injury and impairment of vision. To prevent this complication, epinephrine should be administered by dropping it into the eye (one drop of 1:1000 dilution) immediately upon the appearance of the first sign of severe reaction.

Rarely does a skin test show serious sensitivity reaction in a person with no history of hypersensitivity, and for such persons it is considered proper to perform the skin test in the average physician's office. Then, if there is no dermal reaction to the test, it is deemed relatively safe to administer the prophylactic serum subcutaneously. But if there is positive reaction, the patient must undergo a desensitization procedure.

Subcutaneous Desensitization and Prophylaxis

If there is a history of allergic disease in addition to the positive reaction to the test, desensitization is fraught with danger. To cope with any eventuality, the physician who carries out this work should have at hand a tourniquet, blood pressure apparatus, glucose and saline solutions for intravenous use, oxygen and mask and a tracheotomy set, epinephrine 1:1000 solution, Benadryl®, aminophylline and levarterenol bitartrate (Levophed®), nikethamide and agents for rapid digitalization. Unless all these facilities are readily available, the desensitization process had better be performed in a hospital where everything necessary is on hand and trained personnel is available.

If sensitivity to the antitoxin is demonstrated, further skin testing in series must be done, using successively more dilute solutions until one that causes no reaction is arrived at. That dilution is used as the basis for further desensitization procedures. Desensitization must be done with extreme care, particularly if the reaction to the first test was strongly positive.

A hypothetical example of the method follows:

The skin test is repeated until a dilution is reached at which no reaction was experienced. This dilution is, say, 1:1000. The desensitization then is carried forward, using this dilution for the first dose, then gradually increased doses at gradual increases in concentration as follows:

Dilution:	
1:1000.....	0.10 cc. if no reaction in 20 minutes
	0.20 cc. " " " " " "
	0.40 cc. " " " " " "
	0.60 cc. " " " " " "
1:100.....	0.10 cc. " " " " " "
	0.20 cc. " " " " " "
	0.40 cc. " " " " " "
	0.60 cc. " " " " " "
1:10.....	0.10 cc. " " " " " "
	0.20 cc. " " " " " "
	0.40 cc. " " " " " "
	0.60 cc. " " " " " "
Concentrated serum.....	0.10 cc. " " " " " "
	0.20 cc. " " " " " "
	0.40 cc. " " " " " "
	0.60 cc. " " " " " "

Administration is continued in this manner until 5,000 units had been given as a prophylactic dose.

In this desensitization procedure, if a local reaction develops such as a wheal or erythema at the site of the injection, the safest method is to go back one step and increase the dose more slowly, keeping it at dilutions that do not cause any local reaction.

Should any constitutional reaction appear—hives or generalized itching for example—and wheezing appear with it, the desensitization should be interrupted for intramuscular administration of 0.30 cc. of 1:1000 dilution of epinephrine and intravenous injection of 0.50 cc. of Benadryl® or Chlortrimeton® (5 to 10 mg.). It is advisable to wait 30 minutes

after the cessation of the symptoms of the constitutional reaction before continuing the desensitization, using half the dose that caused the reaction until the required amount of serum is given.

If anaphylactic shock is induced by the sensitization therapy, it must be vigorously treated in a manner described in a later section of this communication under Reactions to Antitoxin.

Intravenous Administration of Antitoxin

The intravenous administration of tetanus antitoxin is limited to the treatment of the disease and is not used for prophylaxis. Before giving antitoxin intravenously, it is mandatory not only to do a careful skin test (some physicians also use the ophthalmic test) but also to test further for sensitivity by giving small doses of antitoxin intravenously and carefully observing the result.

If the reaction to the preliminary skin test is negative, the intravenous test is done by diluting 0.5 cc. of antitoxin with 10 cc. of normal saline solution and injecting 0.5 cc. of this mixture as slowly as possible. If no signs of local reaction appear and there is no significant fall of blood pressure, the patient will usually tolerate the full required amount of the serum.

If there is a positive reaction to the skin test, it must be repeated in series, using successively greater dilutions of the serum until there is no dermal reaction. The final dilution that produced no dermal reaction is the basis for intravenous desensitization and administration. For example, assuming that the serum that produced no reaction was a dilution of 1:1000, the desensitization program is then begun by placing 1 cc. of this dilution in an infusion flask containing 100 cc. of normal saline solution, and this is given by slow intravenous drip. If no reaction develops in the first hour, further doses gradually increasing in strength are administered until the required amount is given. Should constitutional symptoms develop during the administration, the procedure must be stopped and these complications treated. Half an hour after cessation of the constitutional symptoms, the administration may be resumed, but with weaker dilutions, until the patient has received the required amount of antitoxin.

REACTIONS TO ANTITOXIN

Most of immediate reactions are relatively mild, consisting of a wheal, erythema, induration and itching, and usually can be relieved by the oral administration of antihistamines or epinephrine 1:1000 given subcutaneously in a dosage of 0.2 to 0.3 cc.

Occasionally, asthma, wheezing and even edema of the larynx and lungs develop. These reactions are treated by epinephrine (0.3 to 0.5 cc. of 1:1000 dilution intramuscularly) and antihistamines (Chlortrimeton® 5 to 10 mg.) given intravenously. Aminophylline 0.25 gm. to 0.45 gm. in 20 cc. of saline solution infused by vein very slowly (8 to 10 minutes) may be helpful in relieving pulmonary symptoms.

Severe Reactions of Anaphylactic Type. Such reactions develop immediately. One of the early symptoms is a fall in blood pressure, and when this occurs the patient should be immediately placed in the Trendelenburg position.

Other symptoms that may be noted are general weakness, cough, wheezing and generalized itching and hives. Flushing of the skin soon gives way to pallor, cold and sweating. The first step in dealing with the emergency is to give 0.2 cc. of 1:1000 epinephrine at the site of the serum injection to slow the absorption by producing vasoconstriction. Epinephrine (0.3 to 0.5 cc. of 1:1000) is injected into the other arm at 15-minute intervals as indicated. In addition there may be need for administration of oxygen, phenylephrine (Neosynephrine®), levarterenol bitartrate (Levophed®), hypertonic glucose and rapid digitalization. Tracheotomy may be indicated.

Delayed Serum Reactions. Delayed serum reactions are those that do not occur until several hours after the serum administration, and usually they are not serious in character.

Accelerated Serum Sickness. Serum sickness may develop as early as 24 to 48 hours after administration of serum. The early appearance of symptoms often heralds a severe type of serum sickness.

Late Serum Sickness. The vast majority of cases of serum sickness fall into this category. Symptoms do not appear until 7 to 14 days after administration of antitoxin. Usually the symptoms are mild, consisting of hives and itching. Response to antihistamine therapy is usually prompt. But if the prodromal symptoms do not improve rapidly, they often become intensified and a serious type of serum sickness develops. Malaise, fever, adenopathy, angioneurotic edema of the lungs, pleuritis and pleural effusion may occur in addition to the local manifestations. Angioneurotic edema, hives and asthma usually can be relieved by giving 1:1000 epinephrine or 0.05 mg. of ephedrine. Respiratory difficulties can be lessened by intravenous administration of 0.25 to 0.50 gm. of aminophylline in 20 cc. of 5 per cent glucose solution. It is most important to give these agents very slowly. Steroid therapy is most effective for patients who do not respond to antihistamines. It may be begun by giving corticotropin (ACTH) 40 to 60 mg. intramuscularly or 10 mg. (in 1000 cc. of 5 per cent glucose solution) intra-

venously. Prednisone or prednisolone, 4 to 5 mg. three to four times daily, usually relieves the symptoms of the serum disease after a period of two to three days. Since side effects of such treatment are not unusual, the doses should be reduced as the symptoms diminish and discontinued as soon as they are fully abated. Steroids are contraindicated in the presence of active tuberculosis, but if treatment with them is decided upon as a calculated risk in such cases, double doses of antibiotics (500 mg. of Achromycin or Aureomycin four times a day) should be given at the same time. Diabetes is another contraindication, for diabetic coma may develop; and still another is duodenal ulcer, which may be aggravated by steroid therapy.

Generalized itching can be relieved occasionally by the use of procaine solution, 1.0 to 2.0 gm. in 500 to 1000 cc. of 5 per cent glucose by slow intravenous drip. Administration should be slowed or stopped if toxic symptoms such as hyperexcitability develop.

Long Enduring Complications

Fatal complications are rare, but do occur; and it must be recognized that disabilities following severe anaphylactic reactions and serum sickness may persist for a long time.

Neurologic complications occasionally accompany or follow a severe serum sickness. They vary widely from localized neuritis to generalized polyneuropathy.[12,13] The most common is brachial neuritis; and sciatic neuritis is not uncommon. Complications of this kind are often resistant to therapy for weeks, months or even longer.

Substitutes for Horse Serum Antitoxin

Bovine antitoxin produces the same complications as does horse serum in at least 75 per cent of cases. Moreover, it is not always readily available.

Despeciated horse serum* is available. Some of the "impurities" have been removed but the dangers of allergic sensitivities still exist.

Hog and sheep serum are not suitable substitutes.

The Role of Antibiotics in Prophylaxis

It has been shown conclusively that tetanus can be prevented almost always in animals by the use of antibiotics of one of the tetracycline group.[14] On the basis of these animal experiments, it is presumed that in humans, if a tetracycline is given intramuscularly shortly after injury in doses of 500 mg. every eight hours for three to five days, tetanus will not develop. There has not as yet been a sufficient number of humans treated in this manner to permit firm conclusions, but the data that is accumulating is encouraging.

*Treated with an enzyme to break down protein molecules.

SYMPTOMS AND TREATMENT OF TETANUS

The incubation period of tetanus may be no more than one day but the average is 14 days. Symptoms may occur within a day after the injury through which the organism entered. Early development of symptoms always presages a severe and dangerous course. The mortality is in inverse ratio to the time of onset. Since prompt treatment is important, the physician must be alert for the first signs of tetanus. Occasionally the first symptom is local twitching of the masseter muscle.

As soon as a diagnosis is made, the patient should be placed in a secluded, quiet and darkened room. Visitors should be banned, for any stimulus might bring about severe spasms or even convulsions. Trained nursing care is important and the patient should not be left alone.

The wound should be opened widely at once and debridement and irrigation carried out. Total excision of the wound is advisable where possible. Getting rid of the focus of infection is of utmost importance. This has been extended to amputation of a finger or even of a limb in cases of serious infection at the site of compound fracture. Bower[3] said that he had never known a patient in such circumstances to recover unless amputation was done.

Administration of tetanus antitoxin is the standard basic treatment for tetanus, for it is the only agent that will neutralize circulating toxin. It must be given as quickly as possible after the onset of symptoms to prevent the toxin's becoming fixed to nerve tissue. Tetanus toxin has been demonstrated in the circulating blood as long as 48 hours before the appearance of symptoms.

The initial dosage of antitoxin is somewhat controversial, but there is a very definite trend toward larger doses. It is the belief of the authors that at least 200,000 units should be given, half of the amount subcutaneously and the remainder, with caution, intravenously. Bower[3] said that the curative dose is somewhere between 160,000 and 350,000 units. Intraspinal administration is dangerous and has been abandoned.

The intravenous administration of tetanus antitoxin is fraught with danger. It must be borne in mind that the patient may have been sensitized by the prophylactic dose of antitoxin. Careful testing for sensitivity is mandatory, for a severe reaction may cause death. Since repeated doses may sensitize the patient, all serum should be given in the first 48 hours.

Sedative, anticonvulsant and muscle-relaxing agents are most helpful and are used routinely. The numbers and varieties of drugs that have been used are legion. Among these are bromides, amybarbital, chloral hydrate, various barbiturates, and procaine

(1 per cent) used intravenously. Morphine and meperidine are too depressing.

Recently, the best results have been obtained from the following: Tribromoethanol solution (60 to 80 mg. per kilogram of body weight); mephenesin; phenobarbital with mephenesin; mephenesin, barbiturates and chlorpromazine; calcium bromide and chloral hydrate.

Since respiratory complications are the direct cause of death in 80 per cent of fatal cases, a clear airway is important. Tracheotomy may be life saving.

Feeding the patient by the use of a Levine tube maintains the strength. Some observers have suggested gastrostomy but the authors consider this too drastic.

Use of penicillin to combat respiratory symptoms has reduced the mortality. Recently it has been suggested[4,14,15] that antibiotics of the tetracycline group are more specific and evidence is accumulating that they may be useful in human subjects. Florey[8] reported a case of tetanus in an infant who did not respond to antitoxin and penicillin. Chlortetracycline was then used and was credited with saving the life.

Blood transfusions may be of definite value, especially if the donors are known toxoid-immunized subjects, for blood from them may have a very definite specific effect.

It may be noted that when treating children with antibiotics, it is advisable to give, in addition, some gamma globulin, since there is a deficiency of this substance in the first year of life.

Corticosteroids have been tried in the more severe cases of tetanus[5] but they have not been proved to be useful and the authors look upon them with disfavor for the purpose, in light of the fact they are known to depress antibody formation.

DISCUSSION

There are many differences of opinion as to methods of treating patients with tetanus. Some observers[6,7] believe that using epinephrine and Benadryl® in the same solution with the antitoxin will prevent reactions and aid absorption of the serum. The authors do not believe these methods are advisable, since they may obscure a dangerous reaction. Moreover, the drugs themselves may be poorly tolerated. Probably as many patients are hypersensitive to Benadryl® as to the serum itself.

Some investigators[2] emphasize the value of the ophthalmic test while others[3] declare it obsolete. The authors like and use the ophthalmic sensitivity test but the intradermal test is the basic one in use.

Bower[3] has expressed distrust of a negative reaction to a skin test for hypersensitivity and would rely rather on the blood pressure response. The authors believe the blood pressure is an important index but ought not exclude dermal tests.

947 West Eighth Street, Los Angeles 17 (Ross).

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Late Postoperative Intestinal Obstruction

ANGELO M. MAY, M.D., San Francisco

• **Early postoperative intestinal obstruction is most successfully treated with intestinal intubation with a long intestinal tube of the Miller-Abbott, Harris or Cantor type, and only when this fails is reoperation indicated. However, late postoperative intestinal obstruction is better treated by operation as soon as the diagnosis is established and the patient is prepared for the procedure.**

Decompression of the bowel at the time of operation has become a procedure of choice and it is now possible to completely decompress the bowel in the course of the operation using a Foley catheter inserted through a stab wound in the bowel. Details of the technique are described in this article.

EVEN UNDER MODERN CONDITIONS the mortality from intestinal obstruction is high. Early observers, summarizing cases from various sources from 1907 to 1931, gave figures ranging from 32 to 61 per cent. Present experience is perhaps a little better. The cause of death in acute intestinal obstruction is a problem that has engaged the attention of physicians and investigators for over a hundred years. The disease is often dramatic in the suddenness of onset and the rapidity of course. The literature abounds with experimental as well as clinical laboratory data that indicate a variety of nefarious processes that work to deteriorate the condition of the patient.

It is generally recognized that the following factors contribute toward the circulatory failure resulting in early death in untreated or unsuccessfully treated intestinal obstruction:

1. *Disturbance of fluid and electrolyte balance.* As the intestine becomes distended with fluid and nitrogen, the reabsorption of water and electrolytes from the intestinal tract becomes impaired, which results in progressive depletion of water and electrolytes in the intracellular and extracellular compartments. Electrolyte studies of the serum readily reflect these changes.

2. *Circulatory changes.* Distention and incarceration occludes circulation of blood and hence interferes with motility and the functions of absorption and digestion. In these circumstances, the bowel wall is subject to invasion by pathogenic organisms of many kinds, as well as by bacteria ordinarily nonpathogenic, and a large surface of tissue thereby becomes involved in an acute inflammatory process.

3. *Toxins.* Bacterial toxins that develop from bacterial action in the bowel dissipate throughout the body and by action upon the vascular system cause shock and other manifestations of systemic poisoning.

4. *Abdominal distention and splinting of the thorax.* Abdominal distention, with its restriction of the motion of the diaphragm and splinting of the chest in general, results in cardiopulmonary changes which are of considerable importance in the presence of the already serious circulatory changes just mentioned.

5. *Local sepsis.* The embarrassment of the circulation of the distended incarcerated loop of the bowel involved may result in gangrene, rupture or abscess formation in the localized area of obstruction, a serious and potentially lethal situation in itself.

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There are many more components in individual cases which join in the deteriorative process, but in the majority of cases, the factors mentioned should be considered first in the plans for management.

The work of Wangensteen, Cantor, Harris, Abbott and Maddock in our time, particularly their statistical studies indicating a low mortality rate if treatment is begun early, has developed a general awareness that prompt operation is the *sine qua non* in the late treatment of intestinal obstruction. Those investigators have also indicated that most other methods and features of treatment are ancillary, and mainly of great value in the preparation of the patient for the operative procedure or to sustain him during the period when diagnosis is indefinite. The features of early diagnosis and the laboratory and radiological data which confirm the clinical picture are so well documented that they need not be discussed here.

Wangensteen was the first to demonstrate clearly the value of decompression in the management of intestinal obstruction. He used a Levine tube and continuous suction. Miller, Abbott, Harris, Cantor and others furthered the treatment of intestinal obstruction with a long intestinal tube with a balloon feature that facilitates the threading of the tube through the intestinal tract. Maddock showed that in early postoperative obstruction, the mortality rate is lower with the long tube treatment than with im-

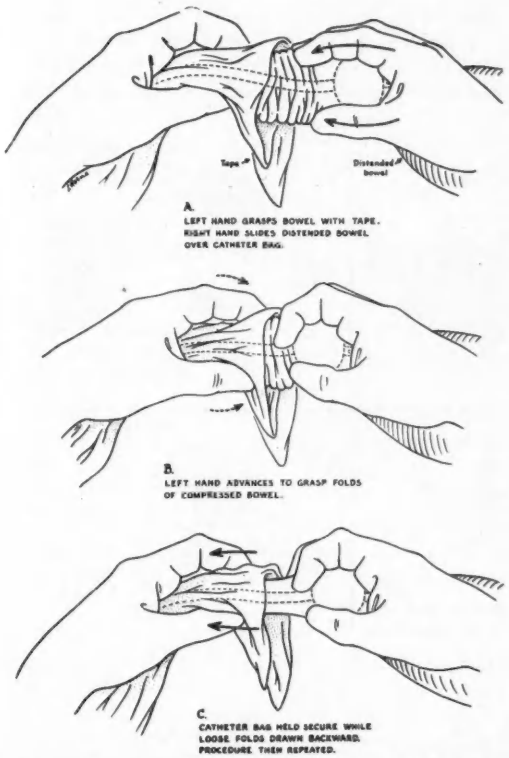


Figure 1.—Method of advancement of ball-tip of catheter through intestine.

mediate secondary operation, and that the reverse is true in cases in which a considerable time has elapsed between the initial operation and the development of obstruction.

Before the era of antibiotics, the opening of an intestine in the presence of obstruction was considered a formidable procedure owing to the hazard of spillage and peritoneal soiling. However, attempts were made to empty the bowel by means of a needle or trocar attached to suction. Cantor found it possible to thread the bowel on a special long decompression suction tip and emphasized the importance of this maneuver.

Wangensteen employed an ordinary French catheter with some degree of success, but this method was not widely applicable owing to difficulty in threading an ordinary catheter very far into the bowel. With the preoperative introduction of the ballooned long tube, it was advocated and occasionally found possible to manually thread the long tube through the bowel from its position in the upper bowel at the time of operation. However, this also sometimes was extremely difficult, particularly when the obstruction was in the lower abdomen.

In 1946, the author began to use the method of introducing a Foley catheter into the bowel at operation, and found the advantage that when the water bag on the catheter was distended, it was possible to draw the catheter through the entire length of the small bowel, first one way and then the other, and thereby completely deflate the intestine at the time of operation (see Figure 1). As experience with this method was obtained, it became apparent that it was possible to prevent spilling through proper introduction of the catheter into the intestine, possible to handle the intestine with great care, and to avoid shock in the handling of the intestine. By this means the bowel could be emptied in situ within the abdomen before it was threaded onto the catheter. Even with the abdomen greatly distended, it was possible to open it and apply this method quickly to empty the bowel and find the point of obstruction.

The procedure is begun by opening the abdomen through a right rectus incision (Figure 2). A distended loop of bowel always rises into the incision as soon as the peritoneum is opened. Whereupon, without delivering the loop, a segment is compressed by a surgical assistant between the forefinger and thumb of his right hand, then the left hand is placed in approximation to the right hand and a small segment of the bowel is emptied of gas and fluid by a pressing, stripping motion between the two forefingers and thumbs. In this emptied segment of bowel, a pursestring suture is placed by the surgeon, and the bowel then is opened and the Foley catheter, which has been attached to the suction, is introduced quickly into the opening and the pursestring suture made taut, closing the bowel snugly about the catheter. The water bag, already tested and attached to the syringe of fluid, is then injected with 10 cc. of sterile saline solution and the butt end secured first by clamping, then by ligation.

Only light suction is used lest the tip of the Foley catheter cleave to the mucosa of the bowel. It is not necessary to determine which way the tip is pointed. With the distended water bag used to advance it, the Foley catheter is pulled through the bowel until the segment is emptied. It is then easy to determine whether the catheter has traveled proximally or distally, for by then a considerable amount of bowel is threaded on it. The first objective in the introduction of the catheter, of course, is to reduce the distention; determining the site of obstruction comes later. If the obstruction is encountered during the first advance of the tube, well and good. It is then relieved and the tube need not be advanced far into the ileum, but it must be withdrawn and threaded into the proximal small bowel until satisfactory deflation is accomplished. Whatever the circumstances, the Foley catheter in each case is followed upward to the proximal jejunum and downward to the region of the ileocecal valve to assure the patency of

the entire length of the small intestine. As obstructions are encountered, adhesions are released and the bowel wall repaired as the occasion requires.

It is well to point out certain precautions to be taken in the use of this method. It is important not to place the pursestring suture until the segment of bowel to be used for insertion of the tube is emptied and kept collapsed by digital compression. Inser-

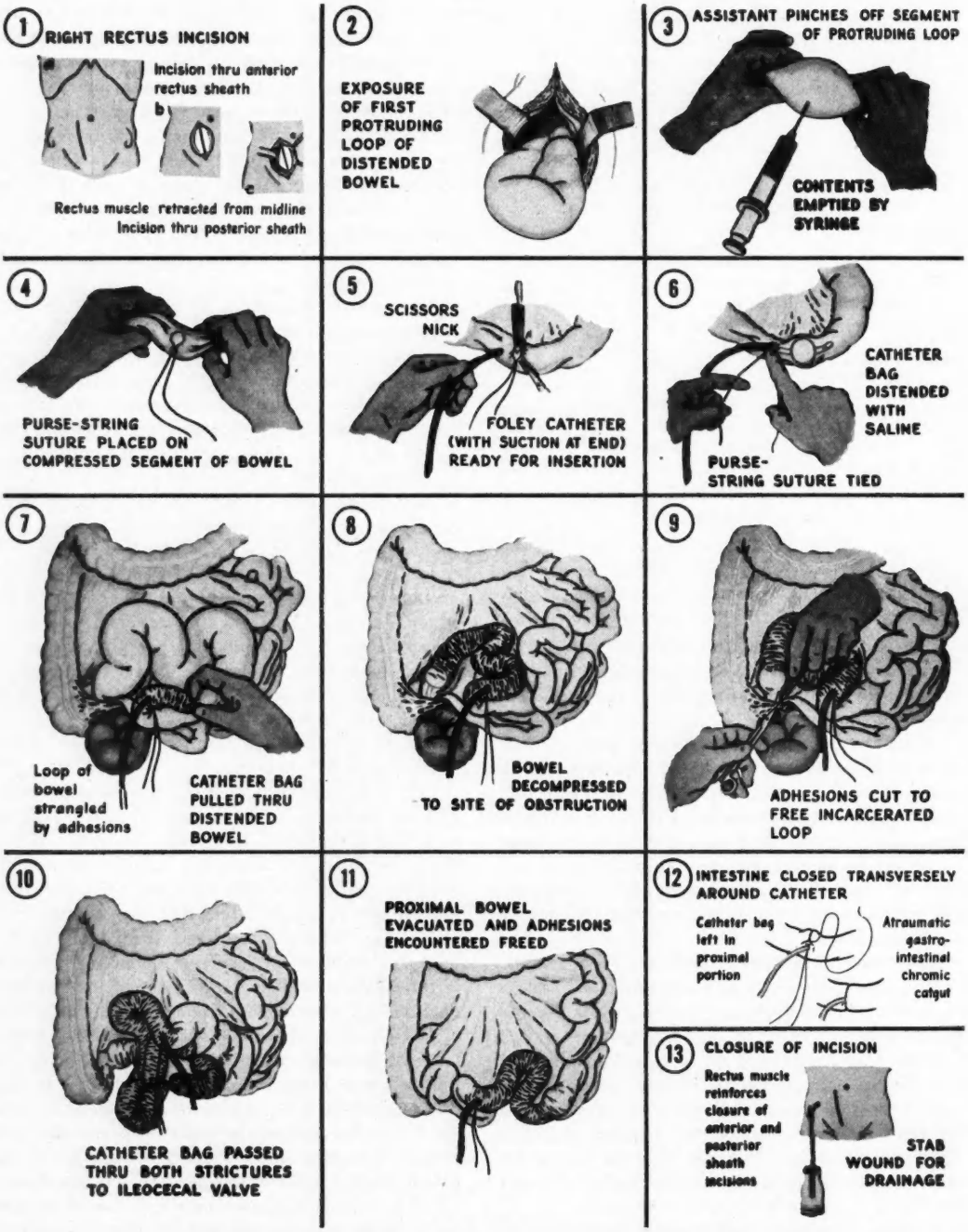


Figure 2.—Procedure for decompression of bowel and reduction of intestinal obstruction.

tion of the sutures while the bowel is still distended may cause material to spurt from it. Unless it pushes through the incision spontaneously, the bowel ought not be removed from the abdomen for introduction of the catheter, for laden and distended as it is it might split open or the mesentery might tear during manipulation. Once emptied, the bowel can easily be taken from the abdomen and inspected its entire length.

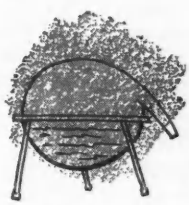
A laparotomy tape placed about the site at which the tube is to be introduced will absorb whatever leakage occurs. After decompression and the freeing of the obstruction, other adhesions which appear likely to lead to further obstruction should also be freed.

Besides serving for decompression, the Foley catheter is brought out through a stab wound in the side as a temporary ileostomy. When the time comes for closing the abdomen, a second layer of sutures is placed to form a valve about the Foley catheter. They are placed transversely from the mesentery border to the Foley catheter on either side as a Lembert suture. It is believed that transverse rather than longitudinal placement of the suture leads to greater patency in the bowel when the tube is removed. The butt end of the catheter is pulled out through the stab wound, the bowel being brought over near to the peritoneum. It is not necessary or advisable to sew the bowel to the peritoneum wall in this area. Indeed in many instances, particularly if the mesentery is short, it is permissible to leave a space of two or three inches between the bowel wall and the peritoneum rather than stretch the bowel to the peritoneal wall. The Foley catheter is connected to a simple gravity drain, and the catheter is irrigated frequently after the first four hours to prevent clogging. It may be secured to the skin by a three-tailed piece of adhesive strapping. The catheter is left in the bowel for at least eight days and preferably ten; then the water bag is emptied and the catheter removed. Leakage from the stab wound is controlled by a dressing, but before it is applied the skin is painted with aluminum paste for protection against the digestive juices.

If the abdomen was greatly distended before operation, considerable time may pass before the motility and secretory ability of the bowel is regained. Hence not much material will drain from the ileostomy tube at first, and it is wise in such circumstances to keep a Levine tube in the stomach attached to suction, mainly for the purpose of keeping nitrogen from entering the bowel through the oral route. With combined gastric suction and ileostomy drainage, the abdomen remains flat until peristalsis returns and the patient can be fed by mouth. Oral feeding may be begun when (1) peristalsis is stethoscopically audible over the abdomen, (2) flatus is passed per rectum, (3) a yellowish rather than black exudate drains from the ileostomy tube, (4) yellow bile is aspirated from the stomach tube, and (5) the patient feels hungry.

Thrombosis in the mesentery does not preclude satisfactory management of the patient with intestinal obstruction, or even management with the method herein described, provided the process is limited. One of the cardinal features of the syndrome of mesentery thrombosis of arterial or venous nature is the intestinal obstruction that results. In some cases, circulatory changes are so severe as to warrant resection of the bowel and anastomosis of the segments. However, even when mesenteric thrombosis is found to be the cause of obstruction, it is considered worthwhile in certain cases to try deflation with a Foley catheter before resorting to resection, for the small intestine is so well supplied with collateral circulation that often there is remarkable return of color to the bowel wall as soon as distention is relieved. If pink color returns and the bowel bleeds when scratched with a knife, it is unlikely resection will be necessary. Decompression ileostomy probably will suffice, care being taken that the tip of the catheter is above the involved area so that deflation of the small intestine continues. Sometimes it may be necessary to insert a second catheter for this purpose.

450 Sutter Street, San Francisco 8.



Routine Cholangiography During Operation For Gallstones

C. C. SMITH, *M.D.*, and GEORGE A. FARIS, *M.D.*, San Jose

• **Cholangiography done routinely during operation was found valuable for detection of stones in the bile ducts. Operation for stone not seen in the operative cholangiogram was seldom necessary.**

When no stone is demonstrated, it seems proper to spare the patient the additional trauma of common duct exploration.

As in many other hospitals, we used to make cholangiograms after the completion of gallbladder operations, injecting the contrast medium through the T tube left in for drainage. In four of 171 such cases in three years, 1952 to 1954, common bile duct stones that had been overlooked at operation were visualized, and reoperation was necessary.

In 1955 and 1956 we began making cholangiograms routinely during operation for gallstones. A mobile x-ray unit rated at 100 milliamperes at 100 kilovolt peak makes practical exposures at a fraction of a second.

In preparing the patient on the operating table, a plywood tunnel is placed under the right side to hold the grid cassette, located between the inferior angle of the scapula and the iliac crest. Nitrous oxide anesthesia avoids explosion hazard.

When the gallbladder has been removed, a polyethylene catheter, size 90, attached to a 10 cc. Luer-Lok syringe is threaded through the stump of the cystic duct past the spiral valves and tied there. Syringe and catheter are filled beforehand with saline solution to avoid introducing air bubbles that could imitate stones in the radiograph. Irrigation to and fro assures that flow is free and that the junction of catheter and duct does not leak.

The syringe is then changed to one holding 20 cc. of sterile 50 per cent Hypaque® or 35 per cent Diodrast® or 35 per cent Urokon®, and to and fro movement of a few cubic centimeters is done again, making sure of a free return of bile without leakage. The syringe is then elevated 2 feet and the common duct filled by gravity, 12 to 14 cc. usually being sufficient.

The x-ray tube is provided with a cone to limit the field to a 10-inch circle. This reduces the exposure of persons in the operating room to an acceptably low level. Immediately after the filling of the bile ducts with contrast medium the film is exposed.

Measurements of radiation about the operating table were made while an abdominal film was exposed. The technical factors were 90 kilovolt peak, 100 milliamperes, 0.3 second, 2 mm. aluminum filter and a 5-inch cone, and 40-inch tube-film distance. The radiation recorded on the right side of the operating table, near the position taken by the surgeon, was 20 to 25 milliroentgens per exposure. Radiation received by the film badge at the head of the table, near anesthetist's position, was approximately 6 milliroentgens per exposure. Thus, from measurements made of scatter radiation, two operative cholangiograms would entail much less than 50 milliroentgens of radiation to the surgeon. This is less than one-half of a week's maximum permissible exposure (100 milliroentgens per week). The anesthetist would receive considerably less radiation than the surgeon.

Film is processed immediately and if appearance suggests a stone in the duct, another exposure is made after irrigation and reinjection of contrast medium. The duct is flushed with saline solution to remove much of the Hypaque before removal of the catheter.

If on opening the abdomen the common duct is obviously inflamed or contains palpable stones, it is usually proper to open it without waiting to do cholangiograms. In such a situation we do the cholangiogram later by introducing the contrast medium through the T tube left in place.

If the gallbladder has already been removed, the injection of Hypaque is made through a needle inserted into the common duct.

REPORTS OF CASES

Following are reports of six cases illustrating various situations in the use of the procedure.

Case 1. The patient was a 72-year-old woman with cholecystitis but no history of jaundice. The

From the Santa Clara County Hospital, San Jose 12.

Presented before the Section on Radiology at the 86th Annual Meeting of the California Medical Association, Los Angeles, April 28 to May 1, 1957.

Revised November 1958.

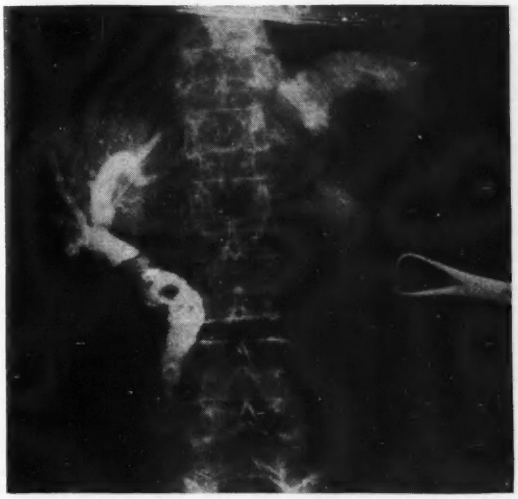


Figure 1 (Case 1).—Common duct stones demonstrated at operation. A polyethylene catheter was used to fill the bile ducts via the cystic duct stump.

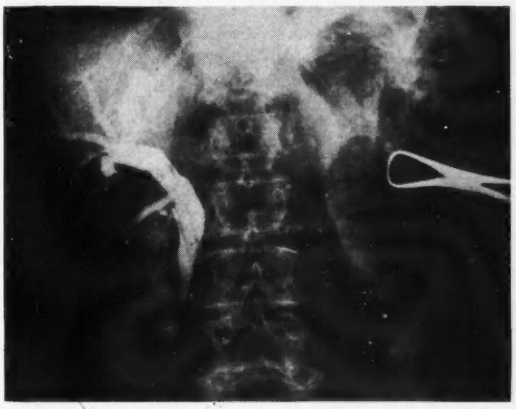


Figure 2 (Case 1).—Cholangiogram made at operation after stones were removed from common duct. The T tube was used for injection.

bile duct was seen to be inflamed and injection of Hypaque was made after removal of the gallbladder. Many small stones were shown in the common duct (Figure 1). These were cleaned out and after the T tube was placed a second injection was made (Figure 2). The patient did well afterward (18 months) although a cholangiogram a few days after operation showed a stone remaining in the hepatic duct.

Case 2. The patient, a 55-year-old man, had had cholecystectomy ten years before. We suspected common duct stone and perhaps pancreatitis. We found the common duct thickened and dilated. It accepted 30 cc. of Urokon by direct injection (Figure 3). The many stones were removed and a T tube cholangiogram showed no stones remaining.

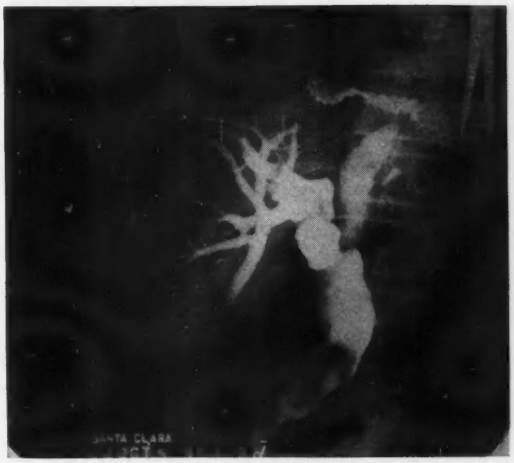


Figure 3 (Case 2).—When the gallbladder has been previously removed, the contrast medium can be directly injected by hypodermic syringe into the bile ducts. Stones are shown in the dilated bile ducts.

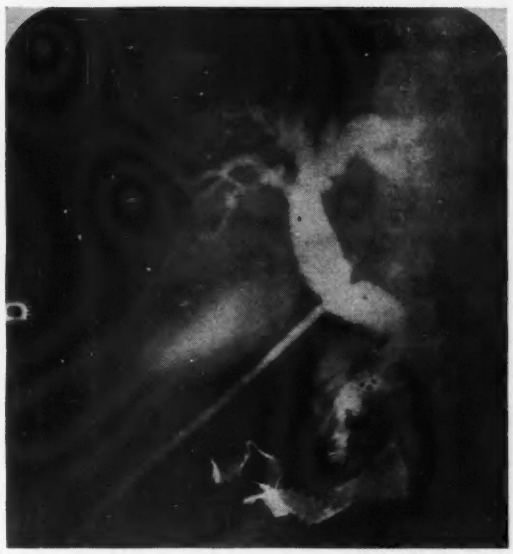


Figure 4 (Case 3).—The patient was a 76-year-old man with icterus, cholecystitis and palpable common bile duct stones. The gallbladder was removed, the common duct explored and a T tube placed. The operative cholangiogram showed remaining common duct stones which necessitated reopening of the common duct.

Case 3. A 76-year-old man with mild jaundice was given Telepaque® by mouth but the gallbladder was not visualized. At operation we saw the cystic duct thickened and dilated, and felt a stone far down the common duct. The gallbladder was removed and

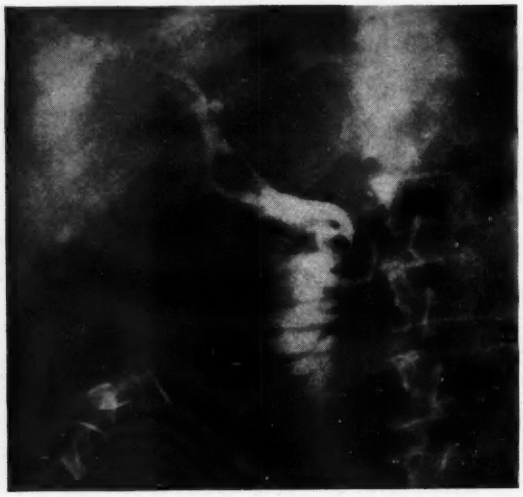


Figure 5 (Case 5).—Common bile duct filled with contrast medium after removal of gallbladder. The stone shown above the ampulla was easily palpated by the surgeon. The stone shown in the hepatic duct was not palpated. All stones were removed.

stones were washed out of the common duct. A cholangiogram made immediately after the T tube was placed showed stones still present above the ampulla (Figure 4) and they were removed.

CASE 4. A 23-year-old woman with questionable history of jaundice had many small stones in the gallbladder demonstrated by intravenous Cholografin®, but nothing abnormal as to the common duct. At operation the gallbladder, duodenum and small intestine were observed to be somewhat inflamed. A cholangiogram made by introducing the contrast medium through the cystic duct catheter after removal of the gallbladder showed some small stones in the common duct. The duct was opened and four stones were removed. A postoperative cholangiogram looked good and the patient recovered nicely. Incidentally, there appeared no symptoms of pancreatitis even though contrast medium entered the pancreatic duct.

CASE 5. A 67-year-old man had had intermittent symptoms of biliary obstruction. At operation the gallbladder was found to be small, thick and hard, the bile ducts dilated. A stone blocked the common duct. A cholangiogram after removal of the gallbladder showed a stone just above the ampulla (Figure 5), and a second stone that had not been felt. Both were removed.

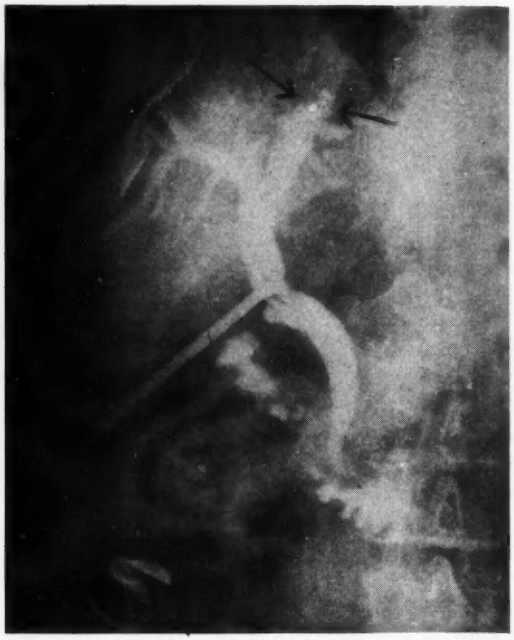


Figure 6 (Case 6).—Obstructive jaundice with stones in the gallbladder and common duct. A T tube cholangiogram, made after all known stones were removed, showed a remaining calculus in the left hepatic duct. This stone could not be removed but the recovery of the patient was fairly good.

CASE 6. A 74-year-old man with obstructive jaundice had calcified stones in a nonfunctioning gallbladder. At operation stones could also be felt in the common duct. Cholangiograms that were made after removal of the gallbladder and exploration of the common duct showed a stone remaining in the left hepatic duct (Figure 6). The patient recovered and is known to have remained well for a year, although the stone was shown still in the hepatic duct several days after the operation.

223 Caldwell Avenue, Los Gatos (Smith).

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The Short-Doyle Act

California Community Mental Health Services Program: Background and Status After One Year

ALFRED AUERBACK, *M.D.*, San Francisco

• **The Short-Doyle Act seeks to encourage the treatment of a patient suffering from a psychiatric disorder in his home community, with the assistance of local medical resources. One corollary of this program is the closer working together of the psychiatrist and the rest of the medical profession.**

A second goal of the act is the application of the public health principles to mental illnesses and mental retardation. Educational and consultative services provide implementation of these principles.

IN RECENT YEARS there has been a striking change in attitude regarding the care and treatment of persons with psychiatric disorders. The present concept is that mentally ill persons, instead of being sent to distant state hospitals, should be treated near their homes, close to family and friends, whenever possible. Acting on the theory that inpatient and outpatient psychiatric treatment in the ordinary general hospitals of the community achieves good results in a high proportion of cases, the California legislature has enacted legislation—the Short-Doyle Act—to initiate or expand community mental health services.

When a person becomes ill, whether through heart attack or broken leg, he expects to go to a local general hospital for treatment. It is now believed that most psychiatric illnesses can be treated in a similar setting, that general hospitals should provide facilities for psychiatric care just as they do for surgical and other medical care. It is believed that this would encourage the mentally and emotionally ill to seek help sooner and that faster recovery could be expected.

BACKGROUND

In 1955 the California Department of Mental Hygiene introduced Assembly Bill No. 1159, patterned after similar legislation passed in New York State in 1954. This measure was designed to establish a community mental health services program including outpatient and inpatient care, rehabilitation, education and consultation services. It passed the Assembly but was tabled in Senate committee. A Senate Interim Committee on the Treatment of Mental Illness was set up under Senator Short to study this matter and to bring in recommendations.

The California Medical Association also began a study of this problem. In May, 1956, a special committee was formed, consisting of Dr. Dan O. Kilroy, Chairman of C.M.A. Committee on Legislation, Mr. Howard Hassard, C.M.A. legal counsel, and Dr. Alfred Auerback, chairman of C.M.A. Committee on Mental Health. A letter was sent to nearly 1,000 psychiatrists throughout the state, asking their opinions on the need for a statewide community mental health services program, and requesting suggestions as to how such a program should be organized and financed. Some 250 answers were received, all expressing the need for this program. There were no dissents.

A series of meetings with physicians, psychiatrists and representatives of lay organizations interested in the mental health field gave the committee a clear picture of the unmet mental health needs in California. In the fall of 1956 the committee began to draft a proposed bill. Since the California Conference on Local Health Officers would be meeting jointly with the Department of Mental Hygiene to draft the regulations when the bill was enacted into law, Dr. Ellis D. Sox, Director of Public Health of San Francisco, as president-elect of the conference, was invited to help in its preparation. The proposed draft was reviewed by various interested groups and won acceptance from all. This suggested program was submitted to Senator Short and his committee, who accepted these recommendations in drafting the new bill. Senator Short introduced the measure in the Senate; Assemblyman Doyle simultaneously introduced it in the Assembly.

The Short-Doyle bill as passed by the legislature contained nearly all the recommendations of the C.M.A. The only major loss in its legislative passage was a section providing for state payments to cities or counties for the care of mentally ill patients who were treated locally even though they did not agree to undergo treatment. This section was intended to apply to patients who are so disturbed that they cannot cooperate voluntarily and therefore have to be

Submitted February 16, 1959.

confined, under court order in order to receive necessary treatment. The legislature felt that the program should be voluntary throughout, counties and cities having the right to choose whether or not to enter the program and patients also having free choice in accepting treatment.

PROVISIONS OF THE SHORT-DOYLE ACT

The Short-Doyle Act provides the means by which local governments wishing to establish a local mental health service may do so, with the state matching local funds dollar for dollar. A city or county may receive state reimbursement for 50 per cent of its net expenditures when it establishes at least two of the following services:

1. Three kinds of clinical facilities directly serving patients: (a) Outpatient services in clinics; (b) inpatient services in general hospitals for a period not to exceed 90 days; (c) rehabilitation services in clinics, general hospitals or special centers.

2. Two kinds of services promoting the mental health of the community: (a) Informational and educational services to the public and to the professions and agencies concerned with mental health; (b) mental health consultation for the staffs of schools, public health departments, probation officers, welfare departments and others to help them to deal more effectively with children's or client's mental health problems before they become severe enough to require psychiatric treatment.

Cities and counties may themselves operate these services or they may contract with a private general hospital, clinic, laboratory or other appropriate agency to provide them. Any person who is "unable to obtain private care," whether for financial, geographical or other reasons, is eligible for inpatient or outpatient care and psychiatric rehabilitation. No patient can be forced into treatment (within the provisions of the Short-Doyle Act) against his will or ordered into treatment by a court. Fees shall be charged in accordance with ability to pay, the local community establishing its own financial regulations. Patients who are under court commitment may be treated in the local general hospital but the community receives no state reimbursement for this treatment under the act.

Local Mental Health Authority

Both the option and the authority to establish local mental health services are given to:

1. Any county board of supervisors to establish services covering the entire county;

2. Any city council of a municipality with a population exceeding 50,000;

3. The board of trustees of a health district (applies only to San Joaquin County).

Joint Mental Health Services

Joint mental health services may be established by two or more counties, by two or more cities with a combined population in excess of 50,000, or by a combination of one or more cities with one or more counties. Joint mental health services may be jointly operated, or one participating city or county may contract to provide service for the others. Costs of services are to be apportioned on the basis of population.

Local Mental Health Advisory Board

Each local mental health authority (local governing body) must appoint an advisory board consisting of seven members: Three local physicians in private practice, of whom one shall be a psychiatrist where possible; the chairman of the local governing body; a superior court judge; and two persons "representative of the public interest in mental health."

The local mental health advisory board is given the responsibility to: (a) Review and evaluate the community's mental health needs, services, facilities and special problems; (b) Advise the governing body as to a program of community mental health services and facilities, and, when requested by such governing body, may make recommendations regarding the appointment of a local director of mental health services; (c) After adoption of a program, continue to act in an advisory capacity to the local director of mental health services.

One of three choices is offered to the governing body: The local administrator of mental health services must be a licensed physician and surgeon, but the administrator who is appointed may be either a specially qualified local director of mental health services, the local health officer or the medical administrator of the county hospital. In effect, the governing body has the choice of utilizing one of its two public medical agencies as the administrative setting for the local program of community mental health services, or the governing body may create a new mental health agency under a local director of mental health services.

Items Subject to State Reimbursement

Cities and counties may claim a state reimbursement of 50 per cent of the net amount expended from local funds for the following items:

1. Two or more of the five specific community mental health services authorized by the act (expenditures are subject to reimbursement whether the local governing body operates its services and facilities directly, or provides them through contract "or by other arrangement pursuant to the provisions of this division").

2. "Such inservice training as may be necessary in providing the foregoing services."

3. Salaries of personnel.

4. Approved facilities and services provided through contracts.

5. Operation, maintenance and service costs.

6. Actual and necessary expenses incurred by members of the local mental health advisory board.

7. Expenses incurred by members of the California Conference of local mental health directors for attendance at regular meetings of the conference.

8. "Such other expenditures as may be approved by the director of mental hygiene."

Certain items are specifically excluded by the act from state reimbursement:

1. Treatment services supplied to patients who are able to obtain private care.

2. The cost of confinement "incurred by reason of court procedures"—that is, expenditures for involuntary patients.

3. Inpatient services in excess of 90 days' duration.

4. Services employing a physician who is not a citizen of the United States.

5. Capital improvements.

6. Purchase or construction of buildings.

7. Compensation to members of the local mental health advisory board.

8. "Expenditures for a purpose for which state reimbursement is claimed under any other provision of law" (such as the special services in public schools that receive state aid through the State Department of Education, for example).

PRESENT STATUS

In the first 13 months, December 1, 1957, to December 31, 1958, eleven counties (Alameda, Contra Costa, Kern, Monterey, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sonoma, Ventura) and one city (San Jose) elected to enter the Short-Doyle program. During this past year these communities spent nearly $2,500,000, receiving almost $1,250,000 in state reimbursement. These communities represent 27.3 per cent of the total state population (4,126,000 persons). Near the end of 1958 the Board of Supervisors of the County of Los Angeles voted to enter the program; hence the counties containing a majority of Californians are now participating in the community mental health services program. As the first year of the Short-Doyle program ended, the boards of supervisors of Fresno and Marin counties voted to appoint mental health advisory boards and the city of Santa Monica voted to enter the program.

In a number of counties, study groups have been organized to explore local mental health needs without actual implementation of the Short-Doyle program. Among these are Solano, Kings, El Dorado, Shasta, Placer, Humboldt-Del Norte, Stanislaus, Tehama, Sacramento and San Benito. The city council of Berkeley has instructed the city manager to include a mental health program in the budget for 1959-60 and will consider it later this year.

In aggregate, the county and city programs now operating under the Short-Doyle Act are providing 42 services, including five inpatient services (146 psychiatric beds), fourteen outpatient clinics, three rehabilitation services and eight educational services. All of them are providing psychiatric consultation services to public agencies. Each community developed the services it required to meet local needs. Some areas focused on children's services, or on inpatient treatment or all-purpose clinics, while others stressed helping patients discharged from state hospitals.

Two pressing problems have appeared with the development of the community mental health service programs. The first is a shortage of trained personnel. There are not enough psychiatrists, psychologists, psychiatric nurses and psychiatric social workers to fill the existing vacancies. As more counties have entered the program the shortage has become more acute. In Monterey County, want of a psychiatric director has prevented operation of a 15-bed psychiatric ward. To meet these personnel shortages the Department of Mental Hygiene held a three-day conference in Berkeley last August, in which all the training institutions in the state participated. These included medical and nursing schools, public and private hospitals, universities and colleges providing education for doctors, nurses and psychiatric personnel. For the next few years the personnel shortages will have to be met through in-service training programs, until these training institutions can begin to provide an increasing number of qualified graduates.

The other pressing problem is that as soon as local services are organized they are overwhelmed by demands for assistance from all quarters. Every clinic has been swamped with referrals. Other community agencies such as the welfare and probation departments, the courts and the schools have sought trained psychiatric help for the many problems confronting them. Because of the heavy demand, every community mental health service has had to establish priorities on the number and the kind of patients that could be accepted for treatment. At the end of January 1959, key personnel of all the existing mental health programs in California met in San Jose to discuss their mutual problems. At this meeting the emphasis was on ways to meet this particular problem and how to provide more psychiatric consultation and guidance to agencies in handling their own

case loads. This group will meet at regular intervals to try to find solutions to the many other problems confronting them.

The California Conference of Local Mental Health Officers was organized in November 1958 with Dr. W. E. Turner of Santa Clara County as its first chairman. This conference, acting jointly with the State Department of Mental Hygiene, evaluates and approves the local mental health programs, and establishes the regulations for their operation.

On July 13, 1957, Dr. Frank A. MacDonald, then president of the California Medical Association, wrote:

"The California Medical Association believes that the Short-Doyle Act (Senate Bill No. 244) which permits psychiatric patients to be treated in general hospitals, which heretofore have infrequently included psychiatric wards, will improve the care of patients with emotional and mental disorders.

"This act should permit more effective treatment in the early stages of the disorder, should allow closer liaison between various medical specialists and should assist the patient mentally by allowing him to obtain complete psychiatric care in his home community, close to his family, his employment and his personal physician."

Any general hospital wishing to establish an inpatient or outpatient psychiatric service, or to enter a local mental health services program if it already has such services, may do so by entering into a contract with the local governing body. For example, San Francisco county in addition to expanding its county hospital services, plans to contract for psychiatric services with four private general hospitals (Children's, Mt. Zion, St. Mary's and St. Francis Memorial). It has long been recommended that general hospitals should allot up to 10 per cent of their beds for psychiatric patients, including alcoholic patients, and the Short-Doyle Act provides a means for accomplishing this. If such an allotment were made, psychiatrists would be encouraged to join hospital staffs and to participate in hospital activities with a mutual sharing of medical experience. The general hospital would become truly general, capable of caring for patients with illnesses of all kinds, both physical and mental. The hospital would man its psychiatric service the same as the medical, surgical or obstetrical service and would be responsible to the local director of the mental health services only for services contracted for with the community.

All the elements in the programs being carried on under the Short-Doyle Act, both at county and state levels, are developing a closer relationship with the county and state medical societies. The C.M.A. Committee on Mental Health meets at regular intervals with the chairmen of the mental health committees of the county medical societies, with the personnel of the local programs and with representatives of the State Department of Mental Hygiene.

In adopting this program, California has struck out in a bold new attack on mental illness. It is probable that more and more general hospitals will make arrangements for care of psychiatric patients with inpatient, outpatient and rehabilitation services. With both the medical profession and the general public becoming oriented to the newer techniques in psychiatry, earlier diagnosis and treatment can be expected. In the last few years the discharge rate from mental hospitals across the country has exceeded the admission rate and this trend should accelerate in coming years as more treatment is provided in the local community.

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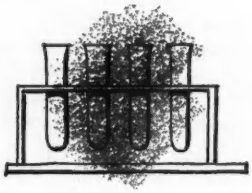

Impalement Injuries of the Hand

Repair of Damage from Broken Bean Poles

STANLEY E. MONROE, *M.D.*, Chula Vista

• **A not uncommon injury of the hands among agricultural workers is impalement on the sharp ends of tomato-vine or bean-vine stakes that shatter as they are being driven. Careful debridement and tetanus prophylaxis are important in treatment. There are several simple precautions and changes in work methods that could greatly reduce the incidence of such injuries.**

INJURIES OF THE HAND caused by impalement on broken stakes happen principally in a few areas where wooden stakes are commonly used as support for tomatoes and pole beans. To drive them, agricultural workers use a tool made from a piece of iron pipe closed at one end and having handles extending along the tube at opposite sides. The top of the stake is inserted into the open end of the pipe, the handles are grasped in the hands and the stake is driven into the ground with a downsweep of the arms.

Injury occurs when a stake breaks and the momentum of the swing carries the worker's hand down upon the jagged end of the piece of the broken stake that is upright in the ground. Nearly all such injuries occur along the radial side of the hand and in a large proportion of them the thenar eminence or a more distal portion of the thumb is damaged. The piece of stake often pierces through soft tissue the full width of the hand, damaging tendons and nerves as well as muscles, but seldom is there fracture of bones. Because of the likelihood of contamination with tetanus organisms, thorough cleansing and careful debridement is essential.

The following case report describing such a hand injury and the method of treatment is typical of some forty similar cases observed in the past few years.

REPORT OF A CASE

A 42-year-old Mexican worker was driving stakes when one of them split and his hand, in downward sweeping, swung down upon the jagged end. A fragment 6 cm. by 1.5 cm.. was driven into the left thumb. The entire hand was carefully cleansed with an antibacterial emulsion (Phisohex) and water. Benzalkonium chloride (Zephiran) solution was used to rinse the wound. Lidocaine hydrochloride (Xylocaine) was injected along the tract of the splinter of wood and the tract was then laid open. The large wood fragment and several smaller pieces were removed. A culture was made of material swabbed from the tract made by the splinter. The tract was loosely closed with a single suture and a dry dressing applied.

After a negative reaction to a skin test for hypersensitivity, 10,000 units of tetanus antitoxin was administered intramuscularly and 0.5 cc. of tetanus toxoid subcutaneously. Aspirin-phenacetin-caffein tablets were prescribed for relief of pain. A sling was provided and the patient was advised to avoid using the hand.

On the following day, the wound was dry. There was a moderate amount of dried blood on the dressing. Three days after injury the wound seemed to be healing well. A new dressing was applied on the fourth day and on the sixth day the patient returned to work. A day later the stitch was removed.

The culture of material from the wound grew Gram-negative bacilli, probably pseudomonas, and Gram-positive bacilli resembling hay bacillus.

DISCUSSION

It is believed that injuries of the kind here described could be largely prevented if the following suggestions were carried out:

1. Wearing leather gloves would protect against penetration by some of the smaller fragments of wood.

2. In certain types of soil, holes can be made with a heavy crowbar to permit the introduction of stakes without the use of a driver.

3. If a driver must be used, a metal guard placed as a skirt below the handles of the driver, would protect the worker's hands.

Because of the likelihood of contamination with tetanus spores, careful debridement and large doses of tetanus antitoxin are required (after skin test with diluted material) for patients not actively immunized with tetanus toxoid.

Tissue response to stakes treated with creosote or with other preservatives may differ from the response to untreated wood. In two cases known to the author, large pieces of wood remained imbedded in tissue, with minimal reaction, over a period of weeks. The likelihood of multiple fragments of wood in this kind of injury should be kept in mind.

765 Third Avenue, Chula Vista.

Mediastinal Emphysema

JOHN E. SUMMERS, M.D., Sacramento

• **Mediastinal emphysema may occur due to migration of air from the lungs, from the esophagus or tracheobronchial tree and from the abdomen. Of especial interest is the mechanism starting with the rupture of the perivascular alveoli due to a rapid decrease in intrathoracic pressure from any cause, the development of pulmonary interstitial emphysema and migration of the air into the mediastinum.**

In one case the patient had severe interstitial emphysema of the left lung, mediastinal emphysema and subcutaneous emphysema without pneumothorax and rapid improvement followed tracheotomy.

In another case the patient had interstitial emphysema of the left lung that did not progress to mediastinal emphysema and subcutaneous emphysema. Pneumothorax was not present. Recovery was more rapid than in the first patient.

SINCE IT USUALLY IS CONCOMITANT with pneumothorax or subcutaneous emphysema, mediastinal emphysema rarely gets more than perfunctory attention. The development of severe subcutaneous emphysema without the coexistence of pneumothorax may turn the mind of the observer to conjecture as to the mechanisms by which the condition came about. The occasional occurrence of subcutaneous emphysema during coughing attacks, asthmatic attacks, parturition, operative procedures, bronchoscopy and esophagoscopy, or spontaneously, may perplex the patient and the physician.

In 1944 Macklin and Macklin[8] published a detailed report on "Malignant Interstitial Emphysema of the Lungs and Mediastinum as an Important Occult Complication in Many Respiratory Diseases and Other Conditions." From their studies, both clinical and experimental, they found that a rapid decrease in intrathoracic pressure caused rupture of the perivascular pulmonary alveoli. This permitted the development of interstitial emphysema of the lung and, with migration of the air toward the hilum of the lung, mediastinal emphysema. The air within the interstitial tissues of the lung can also migrate beneath the visceral pleura and form blebs, which may rupture, giving rise to pneumothorax.

The air within the mediastinum may rupture through the mediastinal pleura, causing pneumothorax, it may migrate cephalad, causing subcutaneous emphysema or it may migrate caudad, causing pneumoperitoneum. Air in the anterior mediastinum gives rise to a loud crunching sound, Hamman's sign, with each heart beat.[6]

Clinically, mediastinal emphysema is not ordinarily of much importance because the mediastinal or visceral pleura usually ruptures and the air is released from the mediastinum into the pleural cavity. This was shown very well by the recent work of Webb, Johnston, and Geisler.[14] Experimenting with rabbits and dogs, and with humans at the autopsy table, they introduced air into the mediastinum and observed that the result was first mediastinal emphysema, then movement of the air along the fascial planes to bring about pneumothorax. "At no time were we able to develop a persistent pressure within the normal mediastinum greater than about 5 mm. Hg," they said, concluding that mediastinal emphysema must rarely cause symptoms and that whatever symptoms do occur are probably owing to associated pneumothorax. They also emphasized that the mediastinal emphysema they studied is completely different from that which is a concomitant of interstitial emphysema of the lungs. The pneumothorax is treated by inserting a tube into the pleural cavity and carrying out underwater seal drainage, thus relieving the pressure. If the mediastinal or visceral pleura does not rupture, however, the continued accumulation of air within the mediastinum may cause a high intramediastinal pressure to build up and obstruct the flow of blood from the lungs to the heart. In this situation great relief may result from a cervical incision and tracheotomy.[10,11]

Air may enter the mediastinum in several ways:

1. Any occurrence which can cause rupture of the perivascular pulmonary alveoli—such as coughing, straining at stool or parturition, trauma in an automobile collision—or spontaneous rupture can give rise to interstitial emphysema and its sequelae, mediastinal emphysema and subcutaneous emphysema with or without pneumothorax.

2. Perforation of the trachea, bronchi or esophagus due to foreign body, instrumentation, ulceration or trauma.

3. Operations in the neck, especially in association with tracheotomy or thyroidectomy. The exact mechanism of occurrence of mediastinal emphysema in association with these operations is somewhat controversial.[12] Does the air enter through the incision—that is, is it aspirated from above, or does

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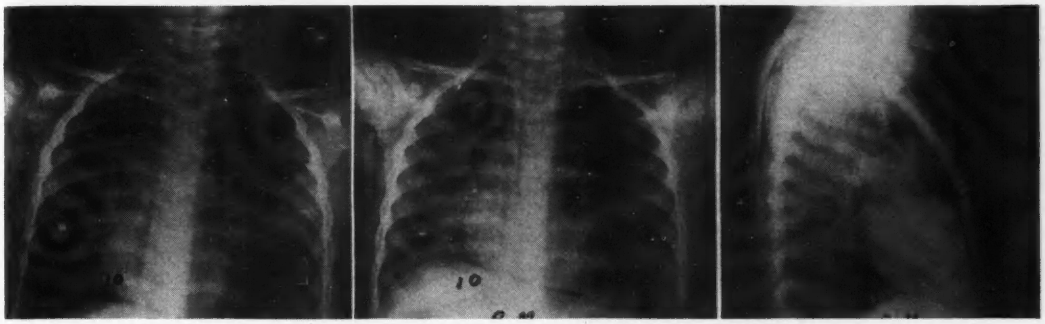

Figure 1 (Case 1).—X-ray films taken on admission to the hospital. *Left:* Film taken after inspiration shows an infiltrate in the left mid-lung field, hyperaeration of the left lung and subcutaneous emphysema. *Center:* Film taken after expiration accentuates the conditions and shows that the left lung does not deflate as well as the right. *Right:* Lateral view shows the presence of mediastinal and subcutaneous emphysema.

it arise as a sequel of rupture of some perivascular pulmonary alveoli? Conditions causing obstruction of the airway frequently produce great respiratory efforts which may rupture the perivascular alveoli and permit the development of interstitial emphysema of the lung and thus mediastinal emphysema.

4. Perforation of a hollow abdominal viscus. Several instances of mediastinal emphysema resulting from a perforated peptic ulcer have been reported.

5. Air may be deliberately introduced into the mediastinum for diagnostic purposes.

6. Pneumomediastinum has occurred during the therapeutic administration of pneumothorax or pneumoperitoneum.

It has been recognized for some time that interstitial emphysema is more common during infancy and childhood.[1] In 1956 Emery,[4] reporting on autopsy of 14 newborn infants who had interstitial emphysema, stated: "The immediate cause of death in all these infants was air in the pleural cavity and mediastinum with apparent compression of the vessels at the roots of the lungs, producing 'air-block.' The interstitial emphysema in all cases appeared to be due to mucus, with amniotic debris and vernix, causing differing degrees of obstruction in the smaller air-passages of the lungs." Berman[2] reported the case of a normal newborn infant in whom progressive respiratory difficulty and cyanosis developed at 18 hours of age. X-ray films of the chest showed a shift of the mediastinum to the right and atelectasis of the right upper lobe, which was interpreted as being due to lobar emphysema or pneumatocele of the left lung. At left thoracotomy done when the infant was 30 hours old, a left marginal pneumothorax and a mediastinum which contained large bubbles of air was observed. No other abnormality was noted. The mediastinum was opened and the patient recovered, being discharged on the eighth postoperative day.

REPORTS OF CASES

CASE 1. A 28-month-old white girl was brought to the hospital by her parents on February 11, 1958, because of "swollen head and neck." The patient had had a croupy cough for one week and for two days had had grunting respirations, anorexia, headache and pain in the eyes. When, three days before admittance to hospital, the temperature had risen to 103° F., Terramycin (oxytetracycline), was administered, 125 mg. three times a day. The fever persisted and on the day of admittance a physician had given the child an injection of penicillin. After returning home from the physician's office the parents noted swelling of the child's face and neck and, attributing it to penicillin reaction, took her to the hospital.

The patient had had pneumonia at one year of age and no other illnesses. Two siblings had had upper respiratory infections recently.

Upon physical examination the face was noted to be decidedly swollen due to subcutaneous emphysema, the eye-lids so thickened that they were closed. The neck was greatly swollen due to subcutaneous emphysema, and subcutaneous emphysema was also palpable over the upper part of the chest anteriorly and posteriorly. Breath sounds were loud and harsh over the right lung but absent over the left. No definite rales were heard. Breathing was rapid and shallow. The heart rate was rapid, the rhythm regular. No murmurs were heard.

Upon urinalysis, the reaction for acetone was strongly positive. Hemoglobin content of the blood was 9.0 gm. per 100 cc. Leukocytes numbered 8,100 per cu. mm.—69 per cent polymorphonuclear cells, 30 per cent lymphocytes and 1 per cent monocytes.

X-ray films of the chest were interpreted as showing obstructive emphysema of the left lung with mediastinal and subcutaneous emphysema. Also there was an area of infiltration in the left mid-lung field (Figure 1).

The rectal temperature at the time of admittance was 101° F. Breath sounds could not be heard over the left lung. The roentgenologist considered rupture of the esophagus or bronchus. A small swallow

of barium outlined a normal esophagus. Penicillin, 600,000 units every 12 hours, and tetracycline, 125 mg. four times a day, were administered and the patient was placed in a croup tent.

Next day the swelling of the face, neck and upper chest was more pronounced. Respirations were rapid and labored. Swelling of the subglottic area appeared to obstruct the respirations. X-ray films showed obstructive emphysema of the left lung and an increase in the mediastinal and subcutaneous emphysema.

Obstructive emphysema of the left lung due to a foreign body in the left main stem bronchus with interstitial emphysema of the left lung, mediastinal and subcutaneous emphysema were considered as the probable sequence of events.

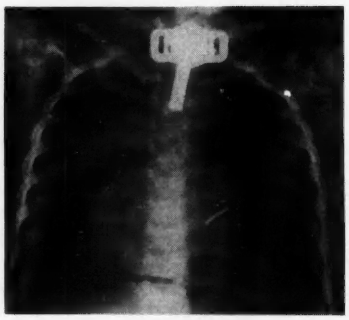

Figure 2 (Case 1). — Film of chest taken after bronchoscopy and tracheotomy shows tube in place, lungs of equal size and the mediastinum in the mid-line.

Accordingly, bronchoscopic examination was performed under general anesthesia. Tracheobronchial aspirate obtained at bronchoscopy was cultured for bacteria and later reported to show no growth. No foreign body was found. Due to the respiratory distress and the severe swelling of the neck caused by the subcutaneous emphysema, tracheotomy was performed. When the transverse cervical incision was made, air gushed out of the tissues, indicating that considerable pressure had accumulated in the mediastinum. A postoperative x-ray film (Figure 2) showed apparent improvement in the lungs.

The temperature rose to 103.3° F. rectally after bronchoscopy.

On the second day in the hospital the rectal temperature declined to 100.8° F. X-ray films showed overdistention and rigidity of the left lung. Breath sounds over the left lung still were absent. The patient was breathing easier through the tracheotomy tube.

On the third day the clinical condition of the patient improved although no change was observed in x-ray films of the chest and breath sounds still were absent over the left lung.

On the seventh hospital day the tracheotomy tube was removed. X-ray films (Figure 3) showed rigidity and overdistention of the left lung. Subcutaneous emphysema was decidedly decreased. On the thirteenth day the patient was clinically well but breath

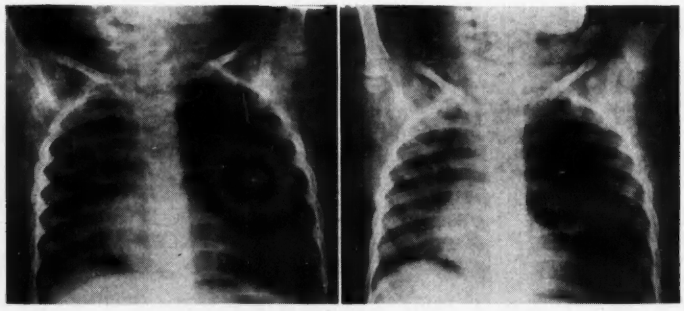

Figure 3 (Case 1).—Six days after bronchoscopy and after removal of tracheotomy tube. *Left:* Film taken after inspiration shows overdistention and hyperaeration of the left lung. The left mid-lung infiltrate is still present. Note pronounced decrease in subcutaneous emphysema. *Right:* Film taken after expiration shows that the left lung is rigid and does not collapse. There is a shift of the mediastinum to the right.

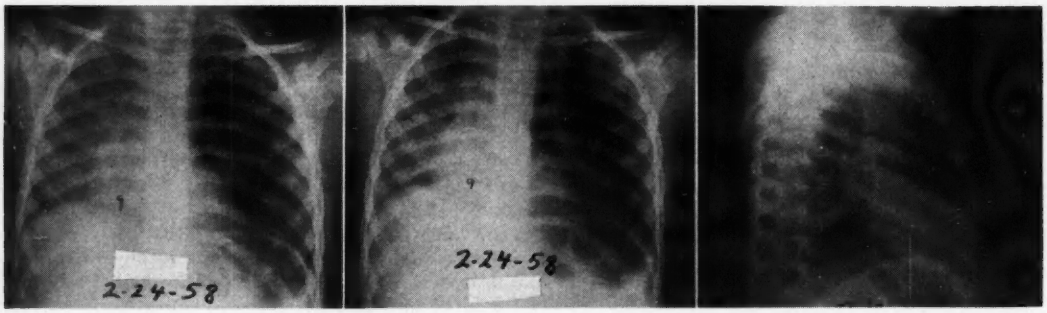

Figure 4 (Case 1).—Films taken twelve days after bronchoscopy. Note complete disappearance of the mediastinal and subcutaneous emphysema. (Breath sounds over the left lung still absent.) *Left:* Film after inspiration shows left lung still slightly hyperaerated and enlarged. *Center:* Film taken after expiration accentuates rigidity of left lung and shift of mediastinum to the right. *Right:* Lateral film shows that the mediastinal and subcutaneous air has now been absorbed.

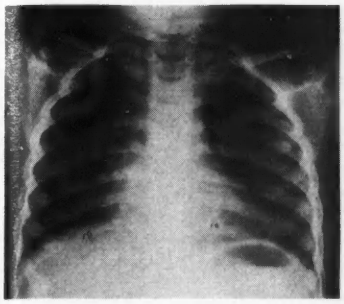

Figure 5 (Case 1).—Lungs normal 19 days after bronchoscopy. (Breath sounds over the left lung were clearly heard.)

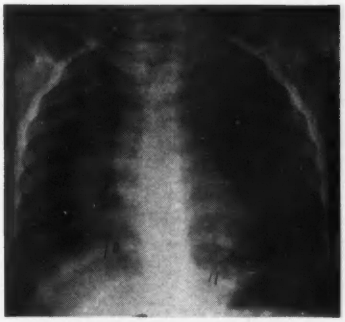

Figure 7 (Case 2).—Film taken on third hospital day shows hyperaeration of the left lung. (Breath sounds over left lung had returned and there was very little mediastinal swing on expiration.)

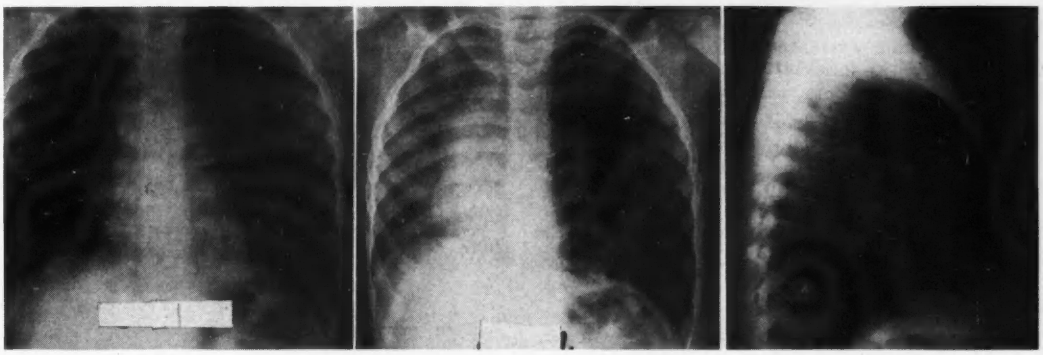

Figure 6 (Case 2).—Films taken on admission show obstructive emphysema of the left lung. (Breath sounds were absent over the left lung.) *Left:* Film taken after inspiration shows some hyperaeration of the left lung. *Center:* Film taken after expiration shows no collapse of left lung and decided swing of the mediastinum to the right. *Right:* Lateral film shows some increase in the anterior-posterior diameter of the chest.

sounds still were absent over the left lung. X-ray films (Figure 4) showed improvement but the left lung was still hyperaerated and did not deflate properly. Not until three weeks after the patient entered the hospital did breath sounds over the left lung become clearly audible. No abnormality was seen in an x-ray film of the chest (Figure 5). Last seen 14 month later, the patient was well and was developing normally. No abnormality was seen in x-ray films of the chest.

Comment. As no definite obstruction of the left main stem bronchus could be demonstrated, it is probable that the sequence of events in this patient was as follows: The severe coughing caused rupture of perivascular alveoli, which permitted the escape of air into the interstitial tissues of the lung, the lung becoming rigid owing to extensive interstitial emphysema, hence not transmitting breath sounds. Then gravitation of air from the left lung along the pulmonary blood vessels toward the hilum of the lung resulted in mediastinal emphysema and then subcutaneous emphysema. Pneumothorax did not occur. Resolution of the subcutaneous and mediastinal emphysema proceeded rapidly but resolution of the pulmonary interstitial emphysema took some time.

CASE 2. A 2-year-old slightly underdeveloped white girl was brought to the hospital February 23, 1958, by her foster mother because of chronic cough and loss of weight. About a month and a half previously the child had partially choked while eating almonds. Since then she had had a chronic cough. She had not eaten well and, questioning indicated, may have had some fever. No information as to past history was obtainable.

The patient was small and thin. She was alert and did not seem acutely ill. The pulse rate was 140, respirations 46 per minute and the rectal temperature 100.6° F. Except for absence of breath sounds over the left lung, no abnormalities were noted in the remainder of the physical examination. The hemoglobin content of the blood was 11.8 gm. per 100 cc. Leukocytes numbered 33,800 per cu. mm., 84 per cent polymorphonuclear cells, 8 per cent lymphocytes, 7 per cent monocytes and 1 per cent basophiles.

In x-ray films (Figure 6) of the chest, hyperaeration and rigidity of the left lung were noted. The mediastinum shifted to the right on expiration. These changes were compatible with foreign body obstruction of the left main stem bronchus.

Bronchoscopic examination was performed three days after admittance. No foreign body was seen, but a small amount of mucus was aspirated. Follow-

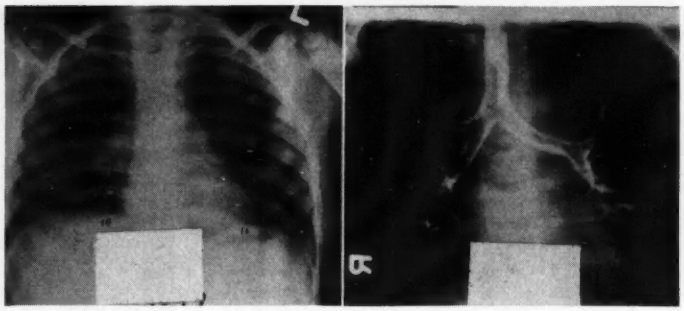

Figure 8 (Case 2).—*Left:* Lungs normal after seven days' hospitalization. (The patient was clinically well.) *Right:* Bronchogram taken on sixteenth hospital day, showing normal tracheobronchial tree.

ing bronchoscopy, breath sounds were heard over the left lung. Considerable improvement in the pulmonary condition was observed in x-ray films. The patient was placed in a croup tent. Penicillin, 600,000 units every 12 hours, and oxytetracycline (Terramycin), 125 mg. four times a day, were administered. From then on the patient was afebrile.

On the fourth hospital day x-ray films showed the left lung was still hyperaerated and did not deflate as well as the right (Figure 7) but breath sounds were heard over it. X-ray films on the sixth day and again on the eighth showed no abnormality either on inspiration or expiration (Figure 8), and breath sounds over both lungs were normal. On the sixteenth hospital day, bronchograms taken with the patient under general anesthesia showed no abnormality. When last seen some two months later, she was progressing normally.

Comment. Here, as in case 1, a child with a severe cough developed evidence of partial obstruction of the left main stem bronchus. The left lung was enlarged and rigid and did not transmit breath sounds. Bronchoscopic examination on the third day of hospitalization did not reveal any definite obstruction of the left main stem bronchus. Although breath sounds were heard over the left lung on the third day of hospitalization, it took about five days for the lung to return to normal roentgenographically. It is assumed that, due to severe coughing, interstitial emphysema of the left lung developed but did not progress to appreciable mediastinal emphysema.

2628 El Camino Avenue, Sacramento 21.

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Hypertrophic Pyloric Stenosis

STEPHEN L. GANS, M.D., Beverly Hills

• **Hypertrophic pyloric stenosis, a relatively common condition, is caused by hyperplasia of the musculature of the pylorus. The diagnosis is made by a history of projectile vomiting and failure to gain weight, the observation of gastric peristaltic waves, and the palpation of a pyloric "tumor." A method of palpating this tumor is described in detail. Roentgenological studies are rarely indicated.**

Pylorotomy for treatment of hypertrophic pyloric stenosis was not successful until the development of necessary supporting measures.

Preparation for operation consists of intravenous administration of fluids and electrolytes and sometimes serum or whole blood. The position of the tumor governs the choice between two different incisions. The operative procedure herein described is essentially that devised by Ramstedt many years ago, with modifications to facilitate the procedure.

ACCURATE DATA on the incidence of congenital hypertrophic pyloric stenosis are not available, but it is probably somewhere between 1 in 200 and 1 in 500 births. It occurs about five times as often in males as in females. More than 50 per cent of patients are first-born children, although only 40 per cent of all children are first-born.[5]

PATHOLOGIC AND ETIOLOGIC FEATURES

The so-called "pyloric tumor" is a firm pale swelling of the pyloric end of the stomach, made up of hypertrophy and perhaps also hyperplasia of the musculature, primarily the circular layer. The blunt distal end projects into the duodenum in the manner of the cervix into the vagina. A longitudinal cut section of the mass has a gray-white, quite avascular appearance and a gristly texture. The mucosa is sometimes quite normal, but frequently edema, congestion or even superficial ulceration is present.

The cause of this relatively common condition remains obscure. It would seem that prolonged pylorospasm with work hypertrophy is the most logical explanation. The spasm could be initiated by the central nervous system, by local abnormal innervation,[8] by local erosions or irritation. Supporting this theory is the fact that the "tumor" disappears after pyloromyotomy but remains after gastroenterostomy. Another phenomenon in accord with the theory is the apparent cure in some cases by nonsurgical methods involving the use of antispasmodics. The theory is weakened, however, by the apparent lack of proof as to what brings about the prolonged pylorospasm. Other factors that cannot be readily fitted to such a postulation are the frequency of familial occurrence[1] and the predominance of the disease in males and in first-born.

DIAGNOSIS

Vomiting is the cardinal symptom. It is caused by obstruction at the plyoric canal, which hypertrophy of the musculature has narrowed. In addition, edema of the mucosa, brought about by prolonged forceful propulsion of gastric contents through the narrowed canal, further reduces the lumen. The time needed for development of these changes is probably why vomiting commonly does not start until the third to the sixth week of life, rarely at birth. At onset, vomiting may simply be mild regurgitation; but it gradually becomes more forceful and then almost always projectile in character. The baby may not vomit every feeding but may retain two or three feedings, then vomit the entire residual. An important point is the eagerness with which the infant will immediately take another feeding soon after vomiting, indicating absence of the nausea that is associated with other causes of infantile vomiting. Because the obstruction is in the pylorus, the vomitus is not bile-stained. The vomitus may occasionally contain a few drops of fresh blood or some "coffee ground" material. In one case observed by the author a tarry stool was passed, probably owing to ulceration of the mucosa.

Other significant information in the history is loss of weight or failure to gain weight. Firmly compacted stools may be noted. In a few cases diarrhea of "starvation type" occurs.

On physical examination the patient usually is observed to be hungry looking, showing signs of dehydration and malnutrition in degrees of severity depending on the duration of the disease. He frequently has a rash around the mouth caused by the irritation of gastric juice. Gastric peristaltic waves may be seen going from left to right across the upper abdomen.

The most important physical finding is the tumor. Palpating it establishes the diagnosis quickly with-

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out need for x-ray study. In all patients observed by the author the mass was palpable. Other investigators have reported similar success.[2,7] Probably it can be done in most cases with patience, perseverance and experienced attention to details. Knowing what to expect to feel is important. Palpated through the abdominal wall, the tumor feels like an olive pit. It cannot be felt unless the infant is completely relaxed, a condition that can be induced by holding a sugar dipped nipple in his mouth. Then, supporting the infant's head and shoulders with the left hand and raising him so that his back is sloped at a 45° angle from the crib mattress in a position that enlists gravity to help bring the tumor into palpable position, the examiner palpates from the right side with the middle three fingers of the right hand.

At first palpation is done lightly, and occasionally the tumor is felt immediately. If not, the examination is conducted more firmly, both through and under the rectus muscle until the entire area is satisfactorily examined. If a mass is felt, it should be pushed away from its location, then felt for again. Palpating it a second time assures the examiner that it is indeed present and that it can only be a pyloric tumor. The tumor is easier to feel after the patient has vomited, but since waiting for him to do so may be inconvenient, a nasogastric tube (a No. 10 or 12 catheter) may be introduced and the stomach emptied if necessary. If the tumor still cannot be palpated, a second or a third examination after lapse of a few minutes may succeed. Failure to detect the tumor by repeated palpation is indication for x-ray study.

Roentgenographic demonstration of the features that are diagnostic of pyloric stenosis is rarely easy and sometimes takes a great deal of perseverance and skill. A dilated stomach, hyperperistalsis and retention of barium are suggestive, but these phenomena may also be present in other conditions. Besides, all these conditions are observable clinically before resorting to x-ray examination. However, demonstrating the narrowed pyloric canal by the "string" sign is considered diagnostic. Sometimes, when the barium enters the duodenum, it will outline the cervix-like protrusion previously mentioned.

Other causes of vomiting in this age group can be differentiated from pyloric stenosis by the absence of a palpable tumor and lack of roentgenographic evidence of pyloric stenosis. In addition, in chalasia of the cardia the persistent cardial relaxation can be demonstrated by x-ray. Pylorospasm, usually intermittent, is relieved by sedatives and antispasmodics. In cases of congenital duodenal obstruction, symptoms are usually present from birth, the vomitus is bile-stained and the x-ray shadows are characteristic. Intracranial conditions, infections and poor feeding methods as causes of infantile vomiting are usually not difficult to identify.

PREOPERATIVE PREPARATION

Pyloromyotomy is not an emergency operation. Adequate time should be taken to prepare the infant for operation. The state of hydration should be studied and chemical contents of the blood evaluated. Some babies with pyloric stenosis retain enough food and are able to compensate sufficiently to keep from losing weight for a short time; and they are ready for operation without further preparation. On the other hand, later in the course of the disease there is metabolic decompensation, and an increasing hypochloremic alkalosis will be found to have developed, as shown by an increased carbon dioxide and decreased chloride in the blood. Replacement should be carried out, using an indwelling intravenous polyethylene catheter in a major peripheral vein.[4] In most instances the amount required for a 24-hour period is 27 to 40 cc. per kg. of body weight (60 to 90 cc. of fluid per pound). Of this total, one-third should be normal saline solution. The problem will be accentuated by catabolic losses of potassium in addition to whatever amount of the ion is lost in the gastric juice. For this reason it may be necessary to add potassium chloride to the solution in the amount of 1 to 2 mEq. per 100 cc. of intravenous fluids when a reasonable urinary output has been noted. It is frequently desirable to add calcium gluconate in amount of 0.5 to 0.75 per kg. of body weight (1 to 2 cc. per pound) to prevent or to treat tetany, because alkalosis causes a decrease of ionized calcium in the blood. If the protein content of the plasma is low, serum is added in amount of 2 to 5 cc. per kg. of body weight (5 to 10 cc. per pound); and if the hemoglobin is low, whole blood is added in the same proportions as serum. The preoperative program should be interrupted and operation performed whenever the infant is in satisfactory condition. It should be altered or prolonged if a satisfactory response is not being obtained. No calculations will take the place of careful clinical observation while replacement is taking place.

OPERATION

For anesthesia the author prefers open-drop ether with plenty of oxygen run in under the mask. Atropine is the only drug used for premedication. Just before the induction of anesthesia, the stomach is emptied carefully with as large a nasogastric tube as can be easily introduced. The tube is left in place during the operation and until the infant is

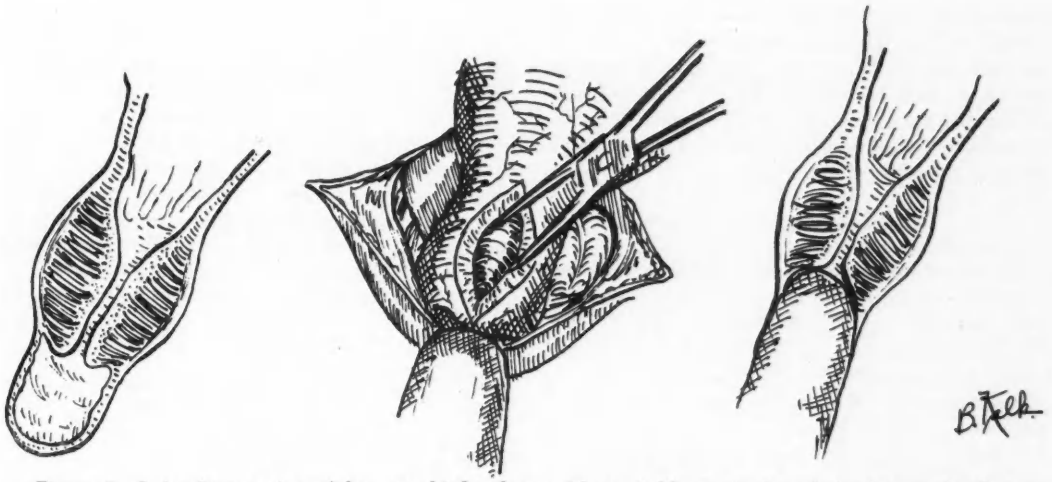

Figure 1.—*Left:* Cross-section of hypertrophied pylorus with cervix-like protrusion of circular muscle. *Center:* Position of finger reducing protrusion while performing pyloromyotomy. Note bulging mucosa. *Right:* Cross-section to diagram the effective reduction, helping to avoid perforation at the dangerous angle.

fully awake from the anesthesia. This will prevent vomiting and aspiration during and after the operation. With the stomach collapsed, delivery of the pylorus into the incision is made easier.

There are two incisions to choose between. If the tumor is palpated in a lateral position, the right upper quadrant gridiron incision serves best. The skin is incised 2 or 3 cm. below the right costal margin and parallel to it. The external oblique and the internal oblique are each spread in the direction of their fibers and retracted. The transversus and peritoneum are opened as one layer and the liver lies immediately beneath. If the "tumor" is in a more medial position, the right rectus muscle splitting incision is used. The skin is incised vertically 2 cm. to the right of the midline, starting just below the costal margin. The anterior fascia is also incised vertically and the rectus muscle spread in the direction of its fibers and retracted. The transversus muscle is usually quite well developed in this region. It too is spread in the direction of its fibers before the peritoneum is incised transversely. With this incision also the liver lies directly beneath; and it is pushed upward with the surgeon's left index finger, while the inferior edge of the wound is retracted by the assistant. A Babcock clamp is passed into the peritoneal cavity by using the back of the left index finger as a guide. It is quite easy to grasp the antrum of the stomach with the clamp and deliver it into the wound. The stomach is held with a moist sponge and so maneuvered as to deliver the pyloric "tumor." Judicious choice of incision permits carrying out this procedure with a minimum of tension on the duodenum.

The tip of the left index finger is then placed against the duodenal end of the pyloric tumor. This, in effect, pushes the protruding muscularis out of the duodenum and helps the surgeon to avoid the dangerous angle (see Figure 1). The tumor is rotated so that the more avascular anterior-superior portion presents, and the antrum is given to the assistant to hold.

An incision is made through the serosa from the pyloroduodenal junction proximally onto the antrum. It is extended somewhat deeper into the muscularis in the center or thicker portion. The muscularis fibers are then spread with a curved hemostat until the mucosa bulges up freely throughout. The most difficult and dangerous area is at the duodenal junction. Here the entire continuity of the ring must be broken without entering the lumen of the duodenum. If such an opening is inadvertently made, it must be repaired and gastric suction maintained for 24 hours after operation. Bubbles of air or bile-stained material may indicate such an opening. If there is any question, the stomach may be inflated with air through the nasogastric tube. The mucosal tear should be sutured with 5-0 chromic or arterial silk and a portion of omentum tacked over the area.

Small bleeding points in the tumor edge are ignored. The ooze is usually due to passive congestion caused by traction of the stomach into the wound. If the pyloric vein itself is divided, it may be sutured a few millimeters away from the edge with 5-0 silk.

When the pylorus is returned to the peritoneal cavity the liver comes down to its position under the incision and offers good protection against

evisceration. The peritoneum and transversus are closed as a single layer with a 3-0 continuous chromic atraumatic suture. The remaining layers are closed with interrupted 4-0 silk and the edges of the skin are approximated with a continuous 5-0 plain subcuticular stitch. A small, light, nonconstricting dressing is applied.

POSTOPERATIVE PROGRAM

There are many regimes of oral feedings for the immediate postoperative period. Most of them serve well, provided certain fundamentals are observed: The infant must not be fed more than he wants, must not be permitted to take too much, must be picked up to be fed, must be "burped" often and thoroughly. The success of postoperative feeding is directly proportional to the nursing staff's attention to the details of care.

Oral feeding may begin when the infant is fully recovered from the anesthesia, usually by four to six hours. He is offered 15 cc. of 5 per cent glucose in water every two hours until three feedings are retained. Then he is offered up to 30 cc. of a 1:5 mixture of evaporated milk and water every two hours until he has retained three feedings. The formula is then gradually increased in amount and concentration so that in 48 to 72 hours he is on a regular feeding regime and is sent home. The avererage time in hospital after the operation is three and a half days. In the first 24 hours, supplementing the diet with parenteral fluids may be desirable, particularly for infants who were in poor condition before operation, or who vomit for a day or two after operation.

The nonsurgical method of management using diet and antispasmodics has been reviewed by Rinvik[10] in the Scandinavian literature. So far as could be determined, the method is not advocated in any of the major centers of this country—for several good reasons. The infant is subjected to from several weeks' to several months' stay in hospital and frequently suffers a severe setback in nutrition, growth and development. The mortality rate is higher than in patients surgically treated. Using the surgical method, hospitalization averages five days, recovery is rapid and the mortality rate almost negligible. The economic aspects are obvious.

9735 Wilshire Boulevard, Beverly Hills.

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A New Simplified Method of Mammaplasty

GEORGE BANKOFF, *M.D.*, Norwalk

• **Abnormally large breasts, which may be a factor in psychic disturbance from an esthetic point of view and which appear to be related to habitual abortion and sterility, can be reduced in size and reshaped by a simpler operative procedure than those now in use. The operation takes considerable less time than others used heretofore. It avoids the need for marking the skin beforehand as a guide to the reshaping procedure and then trying to abide by a preconceived plan, which may be difficult, and it permits the ultimate site of the nipples to be selected after the reshaping is done and even after the skin over the entire breast is completely closed.**

UNLIKE OTHER PLASTIC OPERATIONS, interventions on the breast are of fairly recent origin. There are no ancient records which speak of plastic reduction of the female breast. Yet the procedure is sufficiently old—over half a century—to warrant a better understanding and a better method. Several factors have contributed to this situation. Even when fairly good results have been obtained there has been a certain amount of medical opposition to plastic operations on the breast. The misconception still exists that the reduction of oversized breasts leads inevitably to subsequent inability to lactate, although the most inexperienced physician knows that hypertrophied breasts are, as a rule, physiologically functionless. As to the idea that operations on the breast predispose to cancer, this has been disproved by experience. Actually, the reduction of hypertrophied breasts removes certain pathological conditions which otherwise might lead to malignant degeneration of the glandular tissue. Moreover, there still exists a tendency to overlook or completely ignore the esthetic factor, although grossly deformed breasts can cause innumerable mental abnormalities.

In spite of all this, however, able plastic surgeons have tried for years to devise techniques for the reduction of abnormal breasts. Some of these methods achieve fairly good esthetic results, but none can claim perfection.

Without attempting a full review of the advantages and disadvantages of the existing methods, it may be helpful to point out briefly some of the principal defects. Some of them aim at producing esthetically perfect breasts, even though this entails sacrificing the physiological function; others try to conceal the inevitable scars, with the result that the shape of the organ suffers; yet again, some methods put so much emphasis on preserving the function that neither is the size adequately reduced nor the scars concealed. In addition, all the procedures are very difficult and long—some take from four to six hours. Another fault common to all the techniques to date is that they employ preliminary markings which are supposed to show in advance the position of the nipple and shape of the reduced breast. Experience shows that it is practically impossible to trace lines which will later on fit exactly to the desired shape and position.

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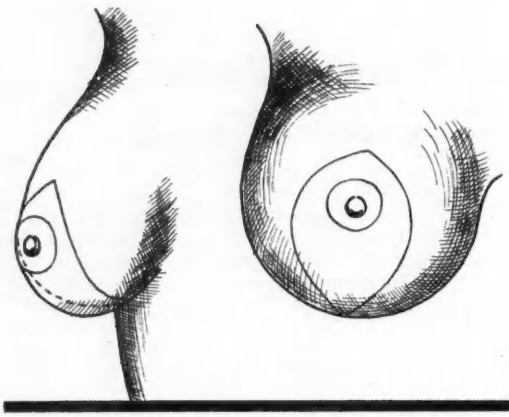
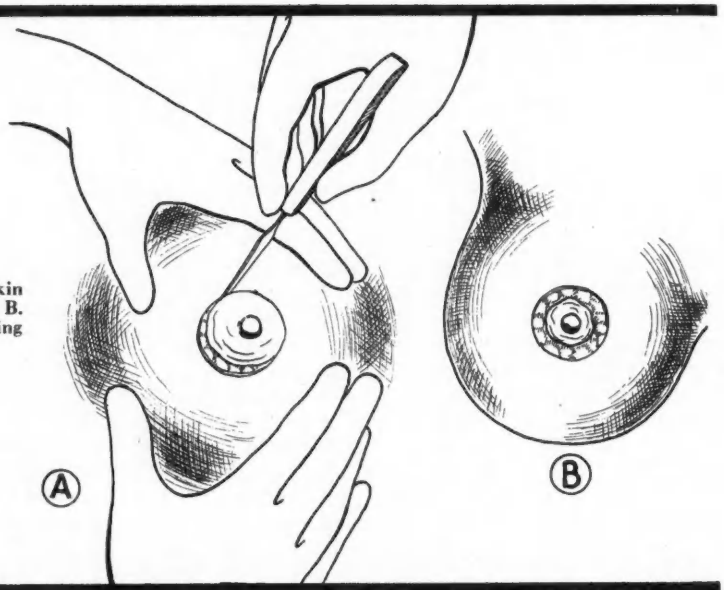
It is obvious, therefore, that the perfect or nearly perfect method would be one that combined the best from all existing techniques while eliminating as far as possible their faults.

In a previous paper[1] I reported observations on a connection between breast hypertrophy and habitual abortion and sterility. And I observed that the plastic reduction of abnormally large breasts prevented abortion and cured sterility in patients who had no other organic abnormality that would cause these conditions.

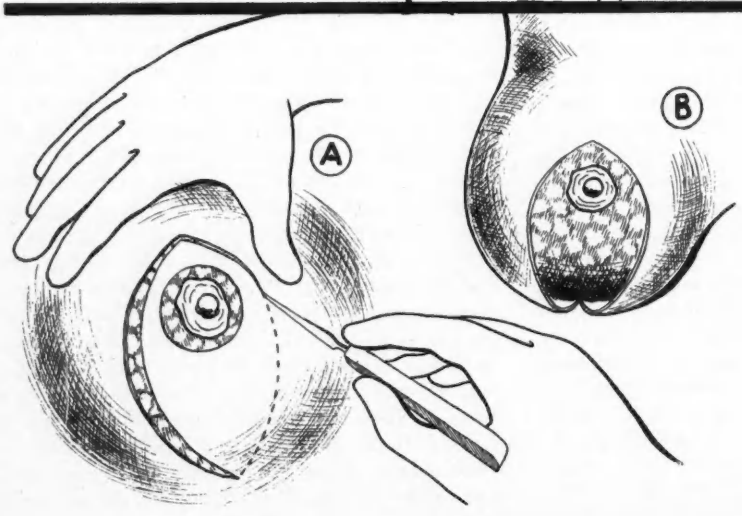
In undertaking the plastic reduction of the hypertrophied gland, consideration had to be given to vital factors. The operation was performed on young women for the principal reason of enabling them to have children. Hence the method adopted had to preserve first of all the function of the gland, at the same time reducing it to about half its original size and giving consideration to esthetic factors. Also, the method had to be simple and take less time than had previously been possible. The technique that was devised to meet these requirements would appear to be a contribution to the advancement of plastic operations on the mammary glands. It is easy to perform even for a general or gynecological surgeon without special training in plastic operations. The technique borrows a good deal, of course, from the work of other surgeons in this field. For the technique here reported, a modified skin incision following the main lines of that devised by Berson is the best; while the S-shape resection of the gland itself originally adopted by Biesenberger, is used for preservation of good blood and nerve supply. Here, however, the similarity



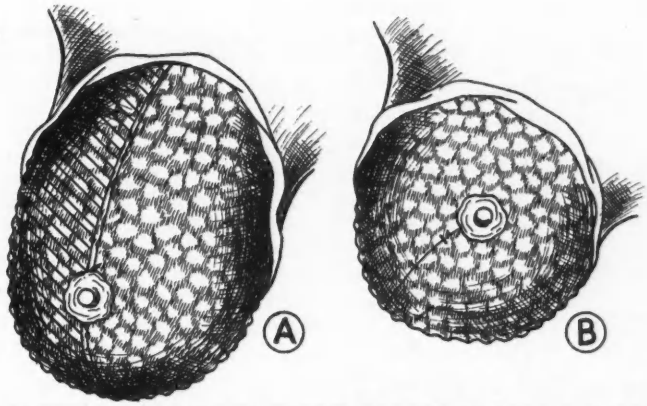
Front and oblique view of the lines of skin incision.



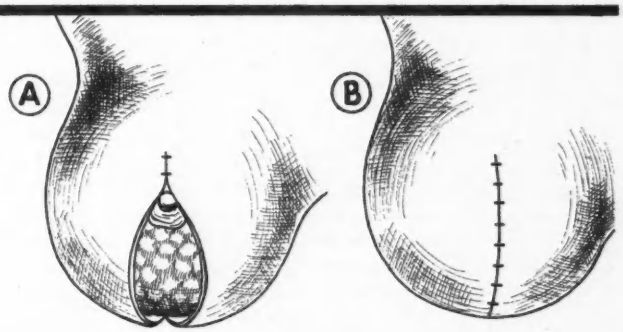
Excision of nipple. A. Skin incision half completed. B. Complete excision showing retraction of nipple.



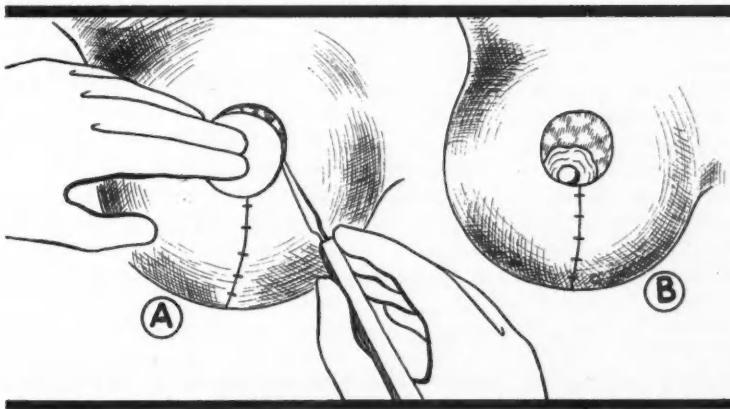
Elliptic incision of skin. A. Skin tightly drawn over breast with incision half completed. B. Skin removed from area within borders of the elliptic incision.



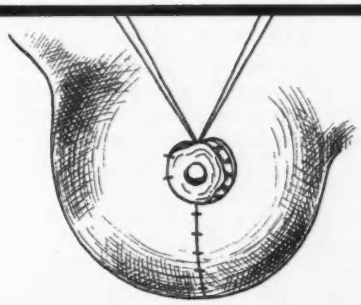
Undermining of the breast. A. Shaded area to be excised. B. Completed reshaped mammary gland.



Suture of skin. A. Placing of interrupted sutures. B. Suture completed with nipple still under skin.



Excision of new areola. A. Excision half completed. B. Nipple showing through the new place of areola.



Suturing of areola in new position.

between my method and those two I have mentioned ceases.

The advantages of the technique are as follows:

It dispenses entirely with all preliminary skin markings which transform the breast into a geometrical puzzle.

It dispenses with the preliminary excision of the new position for the nipple, thus avoiding the inevitable distortions and asymmetry which follow the modeling of the skin upon the reduced gland.

The physiological function of the gland is preserved.

There is only one vertical, or laterally oblique, scar which connects the lower border of the areola to the middle or the lateral third of the submammary sulcus.

An almost perfect natural shape can be obtained and the operation can be performed by a general or gynecological surgeon who has not had training in plastic surgery.

TECHNIQUE

Stage One. After thorough disinfection of the skin, an assistant to the surgeon encircles the nipple with both his hands and retracts the skin tightly and uniformly upon the underlying gland. In this way the areola is stretched to its maximum and the surgeon is able to excise the nipple in a perfect circle, using an ordinary scalpel.

Stage Two. The surgeon draws together the prospective borders of the vertical incision with his two hands, thus forming an opinion of the extent of the skin to be excised. Then an elliptic incision is made, the upper pole of which embraces the excised areola and is at a distance of one to two inches from the skin wound-edge. The lower pole coincides with the mid point or the lateral third of the submammary sulcus. The excess skin is removed with delicate strokes of the scalpel and by blunt separation. The maximum width of the elliptic incision is at the level of the upper third of the space between the nipple and sulcus. With this procedure bleeding is kept to a minimum and no time is lost in ligating bleeding points.

Stage Three. An S-shaped portion from the outer and lower borders of the gland is excised, the amount varying from one-third to two-thirds of the glandular tissue, according to requirements. The portion that is left must include the internal third of the gland to ensure the blood supply of the internal mammary artery. After arresting the slight hemorrhage that occurs, the edges of the reduced gland are brought together by means of interrupted sutures. The nipple is firmly secured onto the reduced organ by interrupted catgut sutures. This will give firm anchorage to ensure blood supply.

Stage Four. The skin is drawn tightly over the gland, the borders overlapping. This makes possible the removal of further strips of skin along the whole circumference of the original incision should that become necessary in the shaping of a perfect breast. No subcutaneous sutures of any kind are applied, interrupted vertical mattress sutures being all that is necessary. Fine silk, silkworm gut, metal clips or any other available material may be used. No attention is paid to the nipple, which at this stage is completely buried beneath the skin. The same performance is repeated on the other breast.

Stage Five. The newly formed breasts are carefully inspected and the new place for the nipples can be easily chosen. For the incision of the skin for the new areolae, one can use a circular piece of metal approximately an inch to an inch and a half in diameter, depending on the size and shape of the breast. After excision of the skin, the buried nipples are easily located and sutured into the new position with interrupted silk stitches. A simple bandage of Elastoplast® is placed on the breasts in such a way as to support and maintain the newly shaped organs. Each breast is bandaged separately in order to facilitate independent inspection and dressing.

The whole operation takes no more than and hour and a half to two hours, instead of the usual four to six hours needed for other methods.

The procedure requires very few instruments. There is no extensive undermining and, as the gland is not traumatized, shock is negligible.

The patient is allowed to get up the day after the operation. On the fifth day, alternate stitches are removed. The remaining sutures are removed on the eighth or tenth day. The patient can usually leave the hospital on the fifth or sixth day—as early as the third day if she wishes to for pecuniary reasons, provided she returns to hospital for removal of stitches and dressings.

Carobil Clinic, 13222 Bloomfield Avenue, Norwalk.

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Medical Preparedness for Disaster

JUSTIN J. STEIN, *M.D.*, Los Angeles

• **The Federal Civil Defense Administration has been consolidated under the President's Reorganization Plan No. 1 of 1958 with the Office of Defense Mobilization. The new organization, the Office of Civil and Defense Mobilization, should be able to deal more efficiently with the problem of mobilization and management of all resources and production of the nation in time of disaster. As preparation for possible enemy attack, organized plans entailing training, supplies, equipment and communications for use in major peacetime disasters—floods, earthquakes, tornado damage—should be carried forward vigorously. Apathy must be overcome. From the local to the highest level all civil defense and disaster plans must be developed and kept flexible enough to be operable during any kind of emergency.**

Physicians must learn as much as they can about the mass care of casualties, how to survive under the most trying of circumstances. Drills in dealing with simulated disaster are of utmost importance for finding out ahead of time what must be done and the personnel and supplies needed for doing it.

UNDER THE President's Reorganization Plan No. 1 of 1958, the Federal Civil Defense Administration and the Office of Defense Mobilization were consolidated on July 1, 1958, to form a new organization in the Executive Office of the President. The new agency is the Office of Civil and Defense Mobilization with Leo A. Hoegh as its director. As Director of OCDM, Mr. Hoegh is a member of the Defense Mobilization Board, and, by statute, of the National Security Council. He regularly attends meetings of the Cabinet at the invitation of the President.

In October of 1958 the Office of Civil and Defense Mobilization outlined the national plan for civil defense and defense mobilization under three major contingencies. These contingencies are international tension, limited war and general war including massive nuclear attack. The plan establishes national nonmilitary courses of action both to deter aggression and for national survival in the event of an attack.

The specific mission of each level of government —federal, state and local—for professional organizations and for the individual citizen are stated in the plan. It is clearly stated that "all citizens and governments at all levels, by virtue of their inherent obligation to support the common defense, are jointly responsible for the civil defense and defense mobilization of the nation.

"The mission of OCDM is

"1. Protection of life and property by preparing for and by carrying out nonmilitary functions to prevent, minimize, repair and recover from injury and damage.

"2. Mobilization and management of resources and production."

There are forty annexes to support the plan, with the National Medical and Health Plan as annex 18.[4]

All plans for major disasters must be flexible. In the short space of 13 years the nominal atomic bomb and multimegaton nuclear bombs have been detonated, the atomic submarine perfected; and in the near future intercontinental ballistic missiles and probably atomic powered aircraft will be ready for use.

It is folly for enlightened peoples to live and plan on the basis that there will be no more wars. The experience gleaned from the study of hundreds of years of history and from the fact that man has changed very little gives convincing evidence that military preparedness is a vital necessity and that wars may occur at any time without warning. Human life does not have the same significance in some areas that it has in the United States. To be less than strong is an open invitation for attack.

Perhaps in the past too much stress has been given to statements that the use of a single megaton hydrogen bomb denotes the destruction of a city, that fantastic numbers of casualties would result from the hydrogen bombing of all the target areas in this country. This may all be quite true, but numerous comments such as these seem to have tended to make the populace, already apathetic on civil defense, more apathetic. Under the best of conditions, civil defense does not have a great deal of popular appeal. The urgent need for organized plans, training, supplies, equipment and communications for use in major disasters should be emphasized because the possibilities of the occurrence of nonmilitary natural disasters, such as floods, earthquakes, plane crashes and train wrecks are ever present in California. The flood in California[1] in December, 1955, was the greatest disaster of its kind that ever occurred in the state. There were 64 deaths attributable to flood conditions, and the financial loss was estimated at $200,000,000 for "direct flood losses" by the California Division of Water Resources.

Presented as part of a Symposium on Medical and Health Services, Region 1 Workshop, San Bernardino, November 19, 1958.

Submitted November 26, 1958.

If local communities are adequately organized, trained and equipped to handle natural disasters, then with additional assistance greater catastrophes can be more adequately managed. The perfection of plans on the federal and state levels has very little value unless the individual on the local level is prepared to play his part. The basic tenets of disaster preparedness are self help and mutual aid.

When one first thinks of a disaster problem such as may occur following a nuclear attack, it seems overwhelming, impossible to cope with. But break the problem down into smaller segments, and especially as it immediately concerns you, and it becomes smaller and the solution appears much simpler. For example, if every individual, or at least one member of every family, should learn first aid, this one objective could help save many lives.

In making medical preparations, it must be assumed that any part of the state at any time is subject to natural disasters of major proportions, with and without warning. Any major disaster may disrupt conditions to such an extent as to make it necessary for the Governor to proclaim a state of disaster or a state of extreme emergency. The state is subject to enemy attack by any or all of the kinds of weapons and methods of delivery available to a potential enemy. Regardless of how well we are prepared and alerted against an enemy attack some of their bomb carrying planes and/or guided missiles, whether released from planes, submarines or fixed installations, will reach the target areas.

From the local to the highest level, civil defense and disaster plans must be developed and kept flexible enough to be operable during an emergency of any type.

The greatest possible use must be made of existing local medical facilities, personnel and equipment. There may be a tendency on the part of some interests to overemphasize their role at the expense of other groups. In the disaster program there is no division that is more important than others—they are all important and their functions and facilities must be coordinated in the overall plan.

The fullest use of paramedical personnel must be made, for they will have to carry the major part of the load. Dentists, veterinarians, nurses with all types of training, dieticians, pharmacists, physiotherapists, medical and x-ray technicians, hospital administrators and many others in the medical field are included under the heading of paramedical personnel.

If we do not have an adequate training program we will not be able to fully utilize these individuals. This also applies to members of the medical profession. Regardless of specialty, all physicians should know the basic principles of disaster medicine. During any great disaster the treatment of mass casualties must be on the same basis as that outlined by the Armed Forces, namely, (1) minimal; (2) immediate; (3) delayed; and (4) expectant. This kind of classification of treatment has to be carried out in order to conserve personnel and supplies and to do the greatest good for the greatest number of persons. A person with a minor injury can be quickly treated and be put back to work, whereas dealing with a person with traumatic abdominal injuries would require the services of many persons and the use of much equipment and materiel. The mass care of casualties must be simplified and standardized as much as possible. Also, the availability of blood and plasma volume-expanders must be stressed.

All personnel must be assigned to specific locations and definite duties, the details to be worked out on the local level. The persons put in charge of triage areas where casualties are sorted should be well trained and have mature medical judgment.

The medical disaster plan must take into account the care of mass casualties from nonmilitary causes as well as those resulting from a nuclear attack and from chemical and biological warfare. The care probably would have to be carried out under conditions of evacuation. Babies will be born, diabetic persons will require insulin, communicable diseases as well as the normal illnesses will be present, and food, clothing and shelter will be required. The rotation of personnel, a system of records and reporting of information for patients and others, the use of utility and mortuary services, blood banks and the coordination of communications and supplies are some of the many things that would present problems during a major disaster. If a disaster occurred from a military attack, from all indications it is quite possible that local areas would have to subsist for as long as two weeks without much direct relief. Certainly, for the first few days little outside help of any type can be anticipated.

The prearranged expansion of existing medical facilities and the utilization of improvised hospitals are of greatest importance. These things cannot be done quickly and effectively without planning and actual testing under simulated disaster conditions.

Many persons have already found out in drills that the 200-bed mobile hospital units now available lack certain equipment which they are supposed to have, that the x-ray films may be worthless, that the generators may not function, and that at least three days is required to make the units functional.

At the recent ninth meeting of the County Medical Societies Civil Defense Conference sponsored by the American Medical Association, it was recommended that a specific study be made of the 200-bed mobile hospital units and how to make them more functional, for they will be called upon heavily in any major disaster.

Short of having a disaster, there is nothing better to stimulate interest in disaster preparedness and to show up existing defects than a good test exercise.

One of the best test exercises ever done in the United States was carried out on June 20, 1958, in Alameda and Contra Costa counties in California on the assumption that a major earthquake had occurred.[2] Some three thousand persons took an active part and all 24 hospitals located in the two-county area, as well as representatives from civil defense and volunteer agencies participated. Within a four-hour period, 2,100 persons with simulated injuries had been collected at a dozen collecting and sorting stations, had been given first aid, loaded into various types of transporting vehicles and delivered to hospitals where definitive medical treatment could be carried out.

It would be a wonderful thing if similar test exercises could be done in strategic areas all over California. Many months of planning and exercises on a smaller scale must be done before an exercise of this magnitude can be successfully undertaken. With stress placed on preparations for nonmilitary disasters, greater public interest can be aroused by using Boy Scouts, high school students and many other segments of the population for special assignments. The use of enthusiastic persons in key positions will do much to lessen the public apathy.

Each hospital, in addition to making a survey of its own facilities, should be fully aware of the number of schools, hotels or other buildings in its vicinity suitable for purposes of expansion or of evacuation of some or all of its patients if need be. Civilians almost invariably think of the hospital as the place to go during or following a disaster. It is quite possible that, in a target area, from 50 to 70 per cent of all existing hospitals and their personnel would be lost following a military attack. One of the requirements of the Joint Committee on Accreditation of Hospitals is that there be adequate hospital disaster planning. "A plan rehearsed at least twice a year, for the reception, care, and evacuation of mass casualties is mandatory for all hospitals."[5]

In the event of a nuclear attack, medical personnel should not expect to have only radiation injury to deal with, for most patients will also have burns, lacerations, penetrating wounds, fractures and the like as a secondary result of the blast. The number and kind of wounds will depend a great deal upon whether the explosion is high in the air, on or near the surface or under water. Most of the patients who have had only radiation injury will not require much medical attention during the first few days but antibiotics, blood transfusions and other measures will have to be resorted to later to combat infection, anemia and hemorrhage.

Medicinal supplies for combating shock, for controlling pain, for the treatment of infection and for dressing wounds must be stockpiled. Provisions must be made for the rotation of drugs which eventually lose their potency. Tetanus antitoxin has an expiration date of three years after its manufacture. Penicillin G tablets remain potent for five years and penicillin for injection is effectual for four or five years after manufacture. Tetracycline, erythromycin and streptomycin in powder form are good for two, three and four years, respectively. One major producer stockpiles insulin for normal use for 24 months, and this two-year supply is maintained, without loss, by replacement with fresh supplies.[6]

The wholesale druggists and the retail pharmacists in this country have on hand for normal use about 45 days' supply of penicillin; the manufacturers have penicillin supplies on hand for nine months' normal demand. It takes from three to four months to produce penicillin. Tetanus toxoid requires about six months to make and distribute, and about four to six months is necessary to make tetanus antitoxin available. That is to say, certain drugs and supplies must be stockpiled at all times if they are to be available in time of grave need.[6]

Federal medical stockpiling has been planned so that numerous small depots will be within a radius of 30 to 100 miles around critical target areas; eventually about 100 warehouses will be available in this country. The warehouses will vary between 8,000 and 20,000 square feet. There are four in California.[7]

Time is precious and we cannot turn the clock back. We must learn as much as we can about the mass care of casualties, about how to survive under the most trying of circumstances. We must know what our own individual responsibilities will be during a major disaster, we must practice the ways to meet them—learn how to use what we have and where it is located.

The price for survival is to be prepared.

University of California Medical Center, Los Angeles 24.

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California MEDICINE

For information on preparation of manuscript, see advertising page 2

EDITORIAL

Tetanus Immunization

ONE OF THE GREAT SATISFACTIONS in the science of medicine is the development of agents which will eliminate or control a disease entity. Yet too often too many persons delay availing themselves of the use of the agent that is proved to be effective.

Public health reports in California show that the incidence of poliomyelitis in the opening months of 1959 is running about double the number of cases recorded in the same 1958 period. A portion of the same report shows that some 70 per cent of the current victims have not had the Salk vaccine shots which provide a high degree of immunity from the paralyzing forms of the disease.

Here is an agent which has had widespread publicity, professional promotion, public appeals, public fund-raising and all the modern gimmicks which Madison Avenue can supply—and yet a large number of people forego its use.

While Salk vaccine has had the advantage of modern advertising and publicity techniques, an even more effective immunizing agent rests in our hands, in the form of tetanus toxoid. Its use has been well established, its record of effectiveness in preventing tetanus has been proved beyond question and its availability accepted *a priori*.

Elsewhere in this issue there appear two articles on tetanus [see pages 318 and 322], one of them by a public health official describing 232 cases of tetanus recorded in a six-year period. The statistics in this paper point to some important conclusions. Tetanus is no respecter of area, of age or of the site where infection occurs. Tetanus caused death in 47 per cent of all cases listed for this six-year period.

Thirty of California's 58 counties reported tetanus cases in the period reviewed and these covered metropolitan and rural areas, mountainous and valley districts, northern and southern counties.

As to causative factors, the list shows a wide variety. These include punctures, lacerations, abrasions, crushed digits, ulcers, burns, infections, surgical complications, compound fractures, gangrene, bullet or knife wounds and even abortions.

Even where tetanus antitoxin was administered following an injury and before the onset of symptoms, a large proportion of the patients died. One of the two articles in this issue emphasizes the hazards of the use of antitoxin and indicates the nicety of decision that devolves upon a physician contemplating use of the serum in a patient with a "tetanus prone" wound.

The physician is thus left with the cold statistical fact that practically any injury which makes an opening in the skin is to some degree susceptible to tetanus infection. Against the possibility of infection he must weigh the knowledge that the use of antitoxin may cause severe disease in a rather high proportion of cases. If the patient has had previous immunization with toxoid, of course, the decision is a much easier one, but unfortunately few patients can provide information as to whether or not they have had tetanus toxoid in the past or, if they do remember it, few can say when the last booster injection was given.

Although tetanus has not been advertised as an important public problem over the years its deadly character has not diminished. Public health records show that in the period 1920-1924, when California's population was much smaller and when immunization was not yet in wide use, there were 264 cases and the mortality was 82 per cent.

While modern records present a striking improvement over those of some years ago, a mortality rate of 47 per cent today represents a shocking challenge. Fortunately, the challenge is one which can be met successfully.

Although the number of cases of tetanus reported does not loom very large in a state with California's population, the fact that immunization is available for a disease known as a killer should call for sober reflection by all physicians.

Before too long a time, we hope, there may be a crash program to secure tetanus immunization for

all our citizens. When such a campaign is organized, it would have at its command all the publicity techniques which have already been applied to venereal disease and to poliomyelitis. With tetanus, the prognosis of immunization is even more favorable than with these other scourges which have been controlled, if not obliterated, through the combination of effective preventive or therapeutic measures and an aroused public and profession.

Until that day comes, it is the duty of every physician to urge tetanus immunization on his patients, to keep records to show when booster shots are due, to impress patients with the importance of maintaining immunity and of being able to tell any attending physician when he had his most recent booster, and to remain ever alert to the death-dealing character of this disease.

Editorial Comment...

The Future of California Physicians' Service

As California Physicians' Service approaches its majority, its physician members can look back on great accomplishments in the field of health insurance and good public relations. They may feel pleased that C.P.S. still is strongly in the hands of the medical profession, remembering that as individuals they have millions of dollars of time and effort invested in the subsidization of its service plans. But the future they can look forward to is far from certain. For some years now C.P.S. has been upon a plateau of growth and activity. What lies ahead?

This is a day when institutions, organizations, industry, labor unions and government put large amounts of money, long hours of work and effort into applied research which is done under direct supervision or indirectly by financial support of separate research organizations, institutes or universities. Experience has shown that applied research pays. The members of the California Medical Association, through C.P.S. have encouraged and supported practical and applied research in the economic problem of medical care. C.P.S. besides being a fiscal agent of the California Medical Association, can be regarded as the applied research arm of the medical profession of California in this increasingly important field of economics. These efforts of California physicians have paid well in offering positive leadership when it was needed, in gaining practical experience for physicians and others, in health insurance and, early in the life of C.P.S., in effectively halting and since then slowing the progress of socialization of medicine.

To what current problems should our economic researches be turned?

I suggest four important steps to which the physicians of California and C.P.S. should give immediate attention.

1. As rapidly as possible, consistent with sound business principles, base all C.P.S. fee schedules on the Relative Value Study with a dollar base in keeping with the usual fees in a geographic area.

2. We must be prepared through C.P.S. to negotiate, whenever necessary, with federal, state and local government units as well as with industry and labor for the establishment of fee schedules which are based on these principles. These fee schedules may be used by those physicians who choose to do so.

3. We must make medical care plans available for persons over 65 years of age, and we must encourage others to offer hospital care plans that will meet the usual needs of this important and increasingly numerous group of citizens. This action would be in keeping with the recommendations of the House of Delegates of the American Medical Association in December, 1958, and with the actions of the Western New York Blue Shield Plan.

4. We must encourage and develop plans which will cover the medical and hospital needs of those people who desire coverage for catastrophic or major medical illness.

In order to meet the needs of these latter two groups (noted in items No. 3 and No. 4 above) in particular, and in the hope of forestalling government establishment of socialized medicine by little and little, the members of the C.M.A. through C.P.S. must act rapidly and must stand ready again, as individuals to subsidize these plans until the plans can be got on their feet. Sound practice may make it desirable at first to attempt initiating these plans in selected localities for purposes of gaining experience and avoiding excessive and unrealistic contributions by participating physicians. Principles of deductibility and co-insurance and indemnity type plans are very important, but in our race against socialized medicine they may need to be modified or possibly even abandoned.

To maintain some measure of independence in practice, to delay and possibly avoid increasing socialization of medicine and to keep control of the economic factors in the practice of medicine, physicians must again be ready individually to subsidize the applied research arm of the C.M.A., namely C.P.S. They must meet these problems with vision, with unity, with honesty and with determination to succeed.

DWIGHT L. WILBUR, M.D.

Presented before the House of Delegates of the California Medical Association, February 22, 1959.

California MEDICAL ASSOCIATION

NOTICES & REPORTS

Transactions of the House of Delegates

San Francisco, February 22-25, 1959

Note: The following report of the transactions of the House of Delegates of the California Medical Association is selected and abridged. A complete transcript of all proceedings is on file in the Association office in San Francisco and available for the inspection of all members.

ELECTION RESULTS

Elections held by the House of Delegates in its final session February 25 brought Doctor Paul D. Foster of Los Angeles to the office of President-Elect of the California Medical Association for the year 1959-1960.

Dr. James C. Doyle was reelected Speaker of the House of Delegates for his fifth term in that office and Dr. Ivan C. Heron was reelected as Vice-Speaker.

In the election of Councilors, who are selected by their own District delegations, Drs. Omer W. Wheeler, Samuel R. Sherman, Ralph C. Teall, Arthur A. Kirchner and Malcolm C. Todd were chosen by their districts to serve additional three-year terms as Councilors. Dr. William F. Quinn was elected to fill the vacancy left by Dr. Foster's selection as President-Elect, Dr. Donald M. Campbell was elected as San Francisco's second council member, and Dr. Byron L. Gifford of Santa Barbara was named by his district to begin a three-year term.

Nine delegates to the American Medical Association were elected, bringing the total of the California delegation to seventeen, equal in size to New York, formerly the largest of the forty-nine (or is it fifty) states. Reelected as A.M.A. delegates were Drs. Henry Gibbons, III, Sam J. McClendon, Eugene F. Hoffman, Frank A. MacDonald, Paul D. Foster and Donald A. Charnock. Elected to their first terms in this office were Drs. Warren L. Bostick, J. B. Price and H. Milton Van Dyke.

As alternate delegates, Drs. Claude P. Callaway, John M. Rumsey, Gerald W. Shaw, J. E. Vaughn, Arthur A. Kirchner and Carl M. Hadley were all reelected. Drs. Francis H. O'Neil, Charles Hudson, Omer W. Wheeler and Samuel R. Sherman were elected to their first terms as alternate delegates.

* * *

REFERENCE COMMITTEES

Committees appointed by Speaker James C. Doyle at the first meeting of the House of Delegates, Sunday morning, April 22, were as follows:

Committee on Credentials: George H. Houck, Palo Alto, chairman. Your Speaker and Vice-Speaker have inaugurated some changes in registration. It was a little bit better, I think, this morning, but there is still room for more improvement.

The Los Angeles delegation subcommittee, E. E.

Wadsworth, Jr., James G. Conti, Howard A. Wood, Bruce B. Rolf.

Alameda-Contra Costa to Yuba-Sutter-Colusa. These are two boards combined into one. Walter F. Carpenter, San Diego; Robert S. Leet, Oakland; Gordon C. Hall, Madera; Edward Ryan, Redding.

Reference Committee 1. (The committee reviews the reports of the officers, the Council, the standing and special committees, and the commissions.) Howard E. Clark, Monterey; Fred E. Bradford, Los Angeles; Forrest M. Willett, San Francisco; Willard Newman, San Diego, alternate.

Reference Committee 2. (This committee reviews the reports of the secretary and treasurer and the executive secretary, and studies and makes recommendations to the House of Delegates on the budget submitted by the Council and the amount of dues for the ensuing year.) Donald M. Campbell, San Francisco; James J. Morrow, North Hollywood; Robert Dennis, San Jose; L. F. Whittaker, Huntington Beach, alternate.

Reference Committee 3. (This committee considers new and miscellaneous business.) John G. Morrison, San Leandro; Joseph W. Telford, San Diego; Elmer F. Gooel, Beverly Hills; Don C. Musser, San Francisco, alternate.

Reference Committee 3A. (This committee was appointed by your Speaker and Vice-Speaker last year to review and report to the House of Delegates on resolutions pertaining to the public assistance program. The same committee has been reactivated for another year.) Robb Smith, Orange Cove; Robert Combs, San Francisco; William Quinn, Los Angeles; Frederick T. Hunt, Santa Ana, alternate.

Reference Committee 3B. (This committee was appointed by your Speaker and Vice-Speaker to supplement the efforts of Reference Committee 3, which in the past has borne a far heavier burden than it should.) Dorothy M. Allen, Oakland, Charles Grayson, Sacramento; Albert Miller, San Mateo; Harold B. Miles, Santa Barbara.

Reference Committee 4. (This committee considers amendments to the constitution and by-laws.) Roderick A. Ogden, Bakersfield; Roberta Fenlon, San Francisco; August Haschka, Santa Monica; Frank C. Melone, San Bernardino, alternate.

Reference Committee on California Physicians' Service Business: John Mayo, Lodi; Cedric Johnson, Santa Rosa; Ben D. A. Miano, San Bernardino; Wilbur Rogers, Glendale, alternate.

The Constitution Study Committee: This committee was initially appointed in 1957 by your Speaker at the request of the House of Delegates. The Council has suggested that this committee be continued another year. The committee, as originally constituted, is, with your permission, continued. There is one exception: Los Angeles now has one councilor district in place of two formerly. Therefore there is one less on the committee. Sam J. McClendon of San Diego, chairman.

* * *

WOMAN'S AUXILIARY

Mrs. Newell Jones, President of the Woman's Auxiliary to the California Medical Association, reported upon the year's activities of that organization, which by following the motto, "Cooperate and Achieve," had successfully completed the work it had outlined for itself for the year.

* * *

PRESENTATION OF 50-YEAR AWARDS

Pins commemorative of 50 years of membership in the California Medical Association were presented to the following physicians:

Dr. Lewis Michelson, San Francisco.
Dr. Thomas L. Blanchard, San Jose.
Dr. George P. Hall, Sunnyvale.
Dr. Carl T. Wallace, Eureka.

* * *

STUDENT A.M.A. REPRESENTATIVES

The representatives from California medical schools to the Student American Medical Association were introduced:

From the College of Medical Evangelists: Fritz Westerhaup, Jr., and Eugene Shakespeare.

From the University of Southern California: Thomas Hines and Hobart Smith.

From the University of California: Kenneth Drellich and Ann Lawrence.

From Stanford University: Charles E. Comfort and Robert Webster.

SUPPLEMENTAL REPORTS

Vice-Speaker Ivan C. Heron called for supplemental reports beyond those previously made by officers and committee chairmen in the Pre-Convention Bulletin.

REPORT OF LEGAL COUNSEL

MR. HOWARD HASSARD

Mr. Speaker and members of the House of Delegates:

Before presenting to you what I fondly hope will be a brief supplemental report, I think I should acknowledge to you and state very briefly my concepts of the new job I have undertaken.

The first annual session of the California Medical Association that I attended was at the Hotel Del Coronado in May, 1936. I have attended every session since. Whatever little knowledge of the affairs of the California Medical Association that I have been able to pick up during that span, I will do my level best to utilize in the capacity of director. Whatever success comes to me cannot be mine, for I cannot achieve any of it alone. We have a staff that is hard working, dedicated and loyal. We have worked and will work as a team. I am in the position of quarterback. If I call the right signals the team will do the job for you. If I call the wrong signals it's my fault, not the staff's. Our effort will be on the over-all scale, to coordinate, to keep the membership, the officers, the Council, the commissions and committees as informed as possible of the affairs of the association.

You heard Dr. West refer to the growth of the California Medical Association. At the time of the 1936 session that I attended, the California Medical Association membership was approximately 5,000. Twenty-three years later it is in excess of 16,000. No one, I am sure, during the depression days of the thirties had the slightest conception of the growth that actually lay ahead. In fact, in the depression all that was thought about really was survival rather than growth.

Every population study that I have examined with respect to California's future indicates that within the next 20 years the population will at least double. Twenty years from now this association will have over 30,000 members. That may seem like a long time ahead. But 1936 seems like yesterday—and that was 23 years ago.

We must have an organization to serve you that is capable of handling double the number of members that now exists, and we will try to do so.

Now, I will switch to the supplemental report of the Legal Department.

Since the time of the report that was published in the pre-convention bulletin, we have appeared on behalf of the Association in two cases that are now on appeal. They are still pending. They involve subjects of tremendous importance to medicine, and I think I should just outline them to you. One case is entitled Wyatt versus Tahoe Forest District Hospital. The case involves a publicly owned hospital in which the medical staff, organized along the lines recommended by the Joint Commission on Accreditation, recommended to the governing board of the hospital that an applicant for staff privileges be rejected. The governing board accepted that recommendation, whereupon the rejected applicant brought suit.

The case has been tried in a trial court and a decision made in favor of the hospital. It is now on appeal.

The issue involved is whether public ownership of a hospital thwarts the standardization of medical staff organization and thwarts the maintenance of high quality of medical care in a hospital by requiring that any citizen who has a license to practice must be permitted access to the hospital.

As I stated, the case is on appeal and it hasn't been decided yet. It will have considerable bearing when it is decided on the effectiveness of the activities both of the California Medical Association and the California Hospital Association that Dr. West previously outlined to you with regard to maintenance of high quality medical care in the hospitals in this state.

A related case that has been decided in just the past week occurred in Fresno. In that case a physician was expelled from hospital staff membership on recommendation of the credentials committee of the staff after investigation and evaluation. Upon being expelled the physician brought suit, not against the hospital, but against the individual physicians who were members of the committees of the staff that had taken the action and made the recommendation. That case was just decided by the trial court this week in favor of the defendant physicians. The decision ought to have a reassuring effect on the activities of medical staffs in the hospitals in this state.

Another case that is likewise on appeal, the outcome of which will have a tremendous future effect on the practice of medicine, is really a series of cases called the Cutter cases. When the Salk vaccine was first introduced to the public in general in 1955, Cutter Laboratories of Berkeley was one of the manufacturers licensed by the Federal Government to produce Salk vaccine. As I am sure every physician in the room knows, a number of instances of poliomyelitis occurred following inoculation with Salk vaccine manufactured by Cutter. Various of the people who suffered poliomyelitis have brought suit against Cutter Laboratories. One of those cases has been tried in the trial court in Alameda County. The jury found expressly that Cutter Laboratory was not guilty of negligence in any form in the manufacture and distribution of its product, but, on the basis of the instruction of the trial judge, the jury stated that it felt it had no alternative but to find that Cutter Laboratories had been guilty of a breach of an implied warranty, that the law of sales, as applied to products generally, implied a warranty to the effect that when you sell goods those goods are fit for the purpose for which intended. If you buy a tire for your automobile, the law says that the manufacturer of that tire has warranted to you that it's fit to be a tire on your automobile.

The Cutter cases are the first instance in this area, and one of the first instances in the United States, I

should say, of the application of the law of sales to biologicals or prescription pharmaceuticals.

A similar attempt has been made with respect to blood, but the courts have uniformly held that the use of blood is a part of the practice of medicine and is not a sale to the patient of the actual blood that is transfused, even though a charge may be made.

If on appeal the rule that is applicable to blood is applied to biologicals in general, then there will be no implied warranty. If, on the other hand, the court on appeal affirms the trial court, that will mean that in the future all use of biologicals and prescription pharmaceuticals will carry with it a warranty against the unknown, that is, a guarantee that it is fit.

Now, when you stop to consider that in the chain between the manufacturer and the actual use of any biological or prescription pharmaceutical there has to be a physician, I am sure that I need not draw a picture as to the effect to be expected over a period of time if the courts should decide that there is a warranty of fitness for purpose intended in the use of all biologicals and pharmaceuticals.

As stated, the case is on appeal. No one knows what the outcome will be.

Finally, I don't wish to impinge on the report of your legislative chairman, but I thought you would be interested in a bill pending in Congress, HR 4700. You might wish to jot down the number. It was introduced on February 18, 1959, four days ago. The author of it is a gentleman from Rhode Island by the name of Forand. The bill is entitled "A bill to amend the Social Security Act and the Internal Code so as to provide insurance against the cost of hospital, nursing home and surgical service for persons eligible for old age and survivors insurance benefits."

Service is defined as including drugs and such medical care as is generally furnished by hospitals as an essential part of hospital care for bed patients. The term "surgical service" is defined as including all surgical procedures, other than elective surgery, provided in a hospital or in case of emergency or for minor surgery provided in any out-patient department of a hospital or any doctor's offices. Surgical services are further defined as including oral surgery.

I thought you would be interested in that bit of current literature. There are other reports, other resolutions that will come before this House. You will act upon them Wednesday. They deal with many of the facets of this subject, but, as I stated, I thought you might be interested in the present best seller. (Applause)

SUPPLEMENTAL REPORT OF THE COUNCIL

DR. DONALD D. LUM, *Chairman*

Mr. Speaker, members of the House of Delegates:

There is in your folder a report of the Special Committee on Aging [see April, 1959, issue of CALIFORNIA MEDICINE, page 291] to the Council of the California Medical Association.

CONCLUSIONS

1. The C.M.A. should continue to join other organizations in identifying the medical care needs of the 65-plus group in California. C.M.A. should emphasize its belief that these needs can be met on a local level, without federal intervention.

2. There is need for more adequate and up-to-date information.

3. There is need for a continuing study program on the part of the C.M.A. and its component county medical societies.

4. The basic responsibility for meeting the problem of aging lies with the citizens of each community.

5. For those not able to purchase their medical and hospital needs, other solutions have been avaiilable in this state since 1870. Our county and state hospital system has some of the finest physical facilities and equipment available anywhere. Approximately one-third of the hospital days for those 65 and over are provided in county hospitals. Administered on a local level, the county hospitals are most responsive to the needs of the communities they serve. This program is sound and continued to receive the endorsement of C.M.A.

RECOMMENDATIONS

This committee recommends:

1. That C.P.S. be authorized and directed to develop realistic prepayment programs for the aged in California and to report back to the Council. Such programs might contain the following essential features, provided such features are actuarially sound and feasible.

(a) Available to all persons 65 and over on a statewide basis.

(b) Itemizing the cost of professional services and hospitalization (if covered).

(c) Utilize the accepted Blue Shield principles with a realistic income ceiling and a related fee schedule.

(d) Utilize, if practical, a method of co-insurance appropriate for people with modest resources.

(e) Those county medical societies that are willing and able to, should be permitted to participate in this program by exercising local control by use of local claims processing as agents for C.P.S.

Should it be necessary for C.P.S. to request some type of financial guarantee against unusual losses in reference to this particular program, it should make a detailed analysis to the Council about such a proposal. If at all possible, however, such a program should be self-supporting on its own merits.

2. That C.P.S., as the California Blue Shield Plan, cooperate with the National Blue Shield Association program for the aged, to the extent permitted by California conditions.

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BOARD OF TRUSTEES OF C.P.S.

DR. ARLO A. MORRISON, *Chairman*

The major portion of my report has been printed in the Pre-Convention Bulletin. However, I seriously doubt that all members of this House have read that, so I would like to stress just one item: During the past year, due to a thorough going-over of all of our administration of C.P.S., we have been able to effect savings that we feel will result in about half a million dollars per year on our regular program. We also have been able to effect savings which amounted to about $100,000 a year on our Old Age Security program.

Inasmuch as my annual report which was printed in CALIFORNIA MEDICINE was prepared in early November, it is essential that a supplemental report be given on developments which have occured in the planning of a program for persons 65 and over.

In light of the report of your Council and its recommendations for C.P.S. study of plans for the 65 age group, it is a pleasure for me to tell you that substantial progress has already been made toward the development of experimental contracts.

Work in this one area is, of course, in addition to C.P.S. accomplishments of past years through which retired persons have been provided with C.P.S. service benefits. You will recall that as early as 1942 C.P.S. established the Continued Membership Health Plan for retired persons leaving a C.P.S. group. Membership in this plan continues to be available without regard for the age, physical condition or past utilization of benefits by the member.

In 1945 C.P.S. made group benefits available to all employed persons eligible, without respect to age, and then, in 1948, all age limits were withdrawn for dependents.

Prior to instructions from your Council, C.P.S. had been developing contracts specifically designed for persons over age 65. These contracts must at first be considered experimental. We do not know now the precise economic limits to which we may reasonably commit C.P.S. But we cannot become informed if we do not experiment, and we must experiment if we are to offer the public quality health protection at reasonable cost.

Basic principles have already been established in setting forth the benefits covering professional services of such a plan, and, with the further guidance which will come from delegates attending this meeting, we believe that C.P.S. wil be offering for sale a realistic plan for persons 65 and over within a few months.

Therefore, the recommendations included in the Council report which you have just heard and the resolutions which may follow concerning programs for the aged do not come with surprise to C.P.S., but we believe serve to strengthen the position and action thus far taken by the Board of Trustees.

I would like to commend the Los Angeles County Medical Association for honoring us, through its *Bulletin* on our twentieth year. I felt it was a very fine edition and very flattering to C.P.S.

In closing, I feel I would be remiss if I did not thank the members of my board who spent many long hours, both at board meetings and committee meetings, in attempting to solve some of these very complex problems. I especially would like to commend our nonmedical members for their regular attendance and contributions that they have made to C.P.S. over the years. (Applause)

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REPORT OF COMMISSION ON PUBLIC POLICY

DR. DAN O. KILROY

Mr. Speaker, members of the House:

The report of the Commission on Public Policy is divided into the reports of the Committee on Legislation and the Committee on Public Relations. This report is necessarily incomplete at this time inasmuch as an act of the people at the last election revised the method by which the legislature operates. The revision will be explained in some detail later by Mr. Read when he addresses this House. It is that revision which has led to a reduction in the number of bills that have been so far introduced, and yet we still have a large number of bills pertaining to the manner in which you practice medicine. It is our estimate that approximately 10 per cent of all of the bills introduced in the state legislature will affect your practice in one way or another.

I would not attempt at this time to try to discuss all the bills pertaining to medicine which have so far been introduced, but there are nine subjects that I feel merit your consideration and that you should be informed about.

The first is the subject of radiation, and as of last Thursday there were ten bills pertaining to this field. Of these ten, three are of primary interest to you as

physicians. One requires registration and inspection of radiation installations, which reduced down to the most common denominator means that if you have in your office, as is common among many physicians, an x-ray machine, it must be registered and inspected by the Department of Public Health.

Another bill which has the blessing of all doctors, I am sure, is one which will eliminate, by law, the use of x-ray or fluoroscope machines in the fitting of shoes.

The third of interest to you is the creation of a radiation coordinating committee under the office of the governor to study the problems of radiation.

Coroners. AB 1049, which is a bill strongly supported by the California Medical Association, clarifies the legal right of coroners to retain tissues as a part of postmortem study.

Blood alcohol tests. Because a physician drawing blood for a blood alcohol test at the order of a peace officer, but without the consent of the individual involved, may be guilty of assault, legislation has been introduced to remedy this situation.

Public assistance. Pursuant to the request of this House of Delegates made last year to the Council, three bills have been introduced to carry out the Council's desired changes in the medical care program. On this subject I feel you will hear further.

Additionally, two bills have been introduced at this session of the legislature to add needy and disabled as a fourth category of recipients under the medical care program.

You will recall that two years ago a bill was introduced to create an agency of government to study and to control the treatment of cancer. It was popularly known as the cancer quack bill. You will also recall that it was referred on the senate side of the legislature to an interim committee for additional study. The additional study was carried out in the past two years, and at the present time the committee has developed a bill known as SB 194, which creates a cancer advisory council in the Department of Public Health. It provides for regulation and control of methods used in the diagnosis and treatment of cancer.

Air pollution. Senate Bill 314 will create a commission of seven members to study air pollution, to coordinate research and to recommend legislation on this subject.

Disability insurers. This is my one semi-amusing report. The subject is SB 475, which seems to be somewhat confused as to the subject of pregnancy, the authors having defined pregnancy as either an injury or an illness. They don't seem to know which it might be. Therefore, being magnanimous, they are going to provide unemployment payments for the period thereof.

Safety belts. As you recall, last year the House of Delegates passed a resolution pertaining to safety belts and asking for legislation on this subject. In accordance with the request of the House of Delegates a bill has been introduced known as AB 664, which states that any car sold in California after January of 1961 must be equipped with safety belts.

Unemployment insurance. This is important to you as doctor-employers. AB 745 would increase the tax base for unemployment insurance from $3,000 to $3,600, which means you will be paying out more money.

That concludes the report on specific bills.

Mr. Speaker, with your permission I would like at this time to ask Mr. Ben Read, executive secretary of the Public Health League, to report to this House.

MR. READ: Mr. Speaker, members of the House of Delegates:

As Dr. Kilroy stated to you, the legislature is now operating under a new system. Proposition No. 9, adopted at the November election, has done away with the old method of having the February recess. The legislature convened on January 5 and will be there for 160 calendar days, 120 legislative days, or until June 19, in continuous session.

That has posed quite a problem because in the past usually all bills, all major bills, had been introduced by February 1 and we could have them digested, get policy from you and the Council, and know what to do about the bills. This year they are coming in slowly and there is no cut-off period. It's been rather a day-to-day matter of attempting to compile them and see what they do. As of last Thursday night, 2,322 bills had been introduced. In a like period in 1957, over 7,100 bills had been introduced. Now, they still have until June 19 to go, so it will probably reach the 7,000 mark. In past years we always found about 10 per cent of the bills had some reference to subjects in which you might be interested, and we find that to be true this year—still about 10 per cent.

After the legislature convened on January 5, one of the first matters of interest was the appointment of committees which are going to consider bills in which you are interested. We feel very fortunate in the makeup of those committees because they are men who will give your problems a fair hearing. The Assembly Committee on Public Health is chairmanned again by Byron Rumford of Berkeley, whom many of you know. The Senate Public Health Committee is chairmanned by Jack Thompson from Santa Clara, and the Senate Committee on Business and Professions has as its chairman Senator Ed Johnson of Marysville. All of the committee members, I am sure, will give you and your representatives a very courteous hearing.

There is another angle, too, in this new setup in the legislature: Any bill introduced must lie in the committee files for 30 days before it can be considered. As a result, very little actually has been done. As of this date only two bills that might be of concern to you have received any action. One is the technical amendment to the Physical Therapy Act and one is the bill which extends the granting of temporary permits to out-of-state nurses. Those are the only two bills that have any relation to the practice that have had any committee hearings to date.

The future, of course, will probably be full of a lot of problems. They will have to be met, as I said, day to day, and we are compiling, and those of you who are on the *Legislative Bulletin* list will receive, a digest of the bills and Legislative Committee list. If any of you do not receive these bulletins and desire to be on the list, if you will address me at the Senator Hotel in Sacramento, I will be very happy to see that you are placed on the list. That is our best way of getting information to you under this system. We have established an office there in Sacramento with Mr. Salisbury and myself on the job, and due to the fact that we feel the encroachment of third party under the practice of medicine is probably going to come through the insurance field, federal insurance, state health insurance, private insurance, health-welfare fund, so forth, we have recently added a new man to our staff who will specialize in watching the insurance situation. If you wish to be on the mailing list or wish to reach us at any time —the Senator Hotel in Sacramento.

We imagine that many of the old-time bills we had to fight in the past will again be with us. We have been told that Assemblyman Burton from San Francisco will introduce another compulsory state health insurance bill, so we will have to be watching for that.

I think, Mr. Speaker, that is about all that we can report at this time because legislation is still young and we are not able to give you much detail, but call upon us or read the bulletins and try to keep us posted.

DR. KILROY: Mr. Speaker, I ask permission at this time to have Dr. Lafe Ludwig, member of the C.M.A. and the A.M.A. Legislative Committees, report to you on matters of national legislative information.

DR. LUDWIG: Mr. Speaker, members of the House, and guests:

In the 85th Congress we had to follow through something like 706 bills pertaining to medicine.

In the 86th Congress we will have pretty much the same type of bills—some good, some bad—with the exception of some 19 passed in the 85th Congress, 13 of which the American Medical Association supported. I think this is significant, in view of the fact that we are always accused of being a negativistic organization: Some 13 we supported, on two or three we took no position, and a couple we opposed.

There will be numerous categories of bills as we have had in the past. I am only going to mention a few, such as the draft bill, which contains a doctor draft, and which is, as of this moment, passed by the House, not for a two-year extension—the bill expires on the third of June—not for a two-year extension, but for a four-year extension. A letter was sent to the committee by the American Medical Association recommending that if this type of discriminatory legislation should be continued, other professions that were needed from the scientific standpoint should be included in the bill.

No. 2 on the list: The Jenkins-Keogh type of legislation. I think it might be fitting at this time to state that this legislation was initially known as the Reed-Keogh legislation. Congressman Dan Reed, who had been in the Congress for some 41 or 44 years, passed away a week or two ago, and he was one of the originators of this type of legislation. A fine old man. This bill, as you know, passed the House in the 85th Congress. It has passed through the Ways and Means Committee to date. There is no doubt that it will pass the House again. However, in the 85th Congress it reached the Senate Finance Committee, the chairman of which is Senator Harry Byrd, a fine gentleman, and a very conservative and thrifty man. As you know, it was hung up there last time. Frankly, I have not too much enthusiasm that it will get far beyond that. If it does in this session of the Congress, it will be only because of the pressure applied on the committee by individuals through their respective senators, demanding that this bill be put before the Senate. So that if you are in favor of it, and certainly all of you should be, you could write to your congressman and also write your senator, requesting that the Jenkins-Keogh type of legislation be given an opportunity to be heard by the Senate and passed upon by the Senate, pro or con.

The third type of legislation which I think is of great importance is health insurance for government workers. Numerous bills have been introduced covering a group of two million workers plus three million dependents. Numerous types of bills have been introduced, running all the way from the federal government participating from a one-third basis to a two-thirds basis, to paying the entire premium on catastrophic insurance.

We come to the fourth type of legislation. Some of you have certainly seen that the Murray-Dingell bill has been introduced again. Initially it was the Murray-Wagner-Dingell bill. Senator Wagner has

passed away, as Congressman Dingell has. It is his son who is now teaming up on the bill with Senator Murray. Also Mr. Forand, who introduced his bill last Wednesday. Mr. Forand has requested—he is now No. 2 ranking man in the House Ways and Means Committee—that he be appointed chairman of the subcommittee to investigate the needs of the aged. It is our understanding that Congressman Mills, chairman of the committee, would rather do away with the present subcommittees than start more subcommittees.

Also, you may have seen in the Senate the special subcommittee has been appointed. Senator McNamara, former labor leader of Michigan, is chairman of the subcommittee. It is our understanding that this subcommittee following the close of the Congress in the fall will adjourn and will proceed around the country to some 20 cities, holding hearings on the needs of the aged, and having open hearings at that time.

The newly-created committee on legislation, American Medical Association Council on Legislative Activities, is meeting in Washington this Saturday, and it is my understanding that Senator McNamara will be our guest for lunch. Maybe we will learn something; maybe we will not.

In the way of prognostication, as this is not an election year I doubt that very much will happen in Washington legislatively pertaining to us this year. However, the roof may fall in next year, which will be an election year, as you know.

In closing, I am not inclined to be pessimistic, but I do have pessimistic tendencies at times. Those who are working with you and for you on your legislative committees wonder sometimes if it's worth while. We have 40 constituent county societies with a chairman of the legislative committee in each society. We set up two meetings, one in the south of the state and one in the north of the state, last 6th and 7th of November, I believe. The expenses were to be paid by the C.M.A. for the chairman of the legislative committee or representative of the county society, and in the two meetings in Los Angeles and San Francisco we had 16 out of 40 societies represented.

I would also like to call it to your attention that the Public Health League, which is your legislative arm, is neglected considerably by the members of this association. It was brought out today that we had some 17,000 members, and yet only some 9,000 deem it necessary to belong to the Public Health League. If the Public Health League isn't doing the things that you want it to do, that's another point; but it seems to me that it makes it a little difficult for those of us who are trying to carry on your legislative chores for you to have such very weak support.

DR. KILROY: Mr. Speaker, Dr. Malcolm Watts, chairman of the Committee on Public Relations, will give the report of that committee.

* * *

REPORT OF COMMITTEE ON PUBLIC RELATIONS

DR. MALCOLM WATTS

Mr. Speaker and Members of the House of Delegates:

Your Public Relations Committee during the past year has been an active, interested and, we hope, effective group. Its meetings have been attended by the Speaker and the Vice-Speaker of this House, and by the Chairman and Vice-Chairman of the Council. The President and President-Elect have served on the committee. Its discussions have included questions of fundamental policy as well as matters of public relations interest which have arisen from time to time. It has continued and strengthened the grass roots program of basic services which has been developed so effectively by the Public Relations Department through the years.

A major concern of the committee has been to translate the broad objectives which were previously adopted by the House into an action program for public relations for the C.M.A. This was done, and a report approved by the Council was widely distributed throughout the Association. This report was favorably received both within and without the profession. The underlying philosophy of this program is a reaffirmation of the fact that the physician and the medical profession exist only for the best interest of the patient, and that our public relations are simply the expression of this fact, in words and deeds, as individual physicians, as spokesmen for our profession, and as county and state medical associations. What is good for the patient is good public relations—and good public policy. Where this is not recognized the profession is subjected to criticism and rebuke.

Your committee is pleased to report that it has received the enthusiastic support of the President, the President-Elect, and other spokesmen for the C.M.A., both in developing this program and making it an increasingly effective reality during this short year.

Your committee has also given considerable thought and discussion to the wider and deeper applications of this action program. An analysis of many factors which have come to affect the practice of medicine has been required. Some of these factors have been reviewed for you in the committee's monthly column in *Newsletter*.

In substance it is found that the great strength of traditional medical practice lies in the personal rela-

tionship between the physician and his patient in which the physician uses his technological training and human understanding to resolve the patient's individual problem. It is further found that the best relationships of organized medicine with the public are expressions of this same concern with the best interests of the individual, who may be different from other individuals, but who together with other individuals comprises the public. It is noteworthy that the best care for this individual patient is often compromised in circumstances where the principle of greatest good for the greatest number is applied in the distribution of medical care, or where the physician receives his compensation from someone other than his patient. It is difficult, perhaps against human nature, for the "company doctor" or the "union doctor" or the "insurance doctor" to have the same interest in the patient as the personal physician or the specialist who depends upon the patient for his livelihood. These personal, human elements in the best medical practice now find themselves in apparent conflict with some psychological, social, political and economic realities of present-day society. Somehow the needs and characteristics of the human individual and those of human society must be fitted together in such a way that the person who is or may become a patient may continue to receive the best in individual medical care.

It has been said that the public relations of the medical profession consists of everything that is said and done in each doctor's office, of every action or inaction of each medical association and of every public utterance of each physician speaking officially or unofficially. It has been said that good public relations is good performance which is understood and appreciated. If both these statements are true, then good medical public relations consists of good performance by each physician and each medical association which is understood and appreciated.

What is the meaning of "good performance"? The technological care of patients by California physicians and in California hospitals is of high caliber, based on continuing education and continual perfecting of standards. It is equal to the best in the world. But it has become evident that this good technical performance is not enough. The circumstances—psychological, social, economic and political—in which this technical care is rendered are equally important. This has long been recognized by C.M.A., and its pioneering studies in these fields have attracted not only local but national interest. Recently, and unfortunately, the intrinsic worth of one study has been obscured and the public misled by circumstances of premature and sensational reporting. The goals of your committee for the year ahead will be to strengthen this good performance in its broadest concept, make it understood and, we hope, appreciated.

1. Your committee proposes to encourage further consideration of psychological, social and economic factors in medical care, and hopes that the professional objective of better care for patients will be respected by those with special interests.

2. Your committee proposes to focus further upon communication—which is the vehicle of public relations. There are crucial problems in semantics. "Quality of medical care" means one thing to a physician and quite another to a labor leader. There is confusion about "freedom of choice." Who is free to choose? What are his choices? Does it apply before or after one gets sick? The "doctor-patient relationship" and "third party" mean nothing to most of the public. We must learn to speak in terms that will make our meaning clear to others. In addition, we must develop increasingly effective two-way channels for communication with component societies, with the membership of the C.M.A., and with the public. New public relations audiences must be reached.

3. Your committee proposes to develop a closer relationship with the public relations committees of component societies, and to assist them to make good performance, not only a scientific but a social reality in each community, in the sense that it becomes demonstrated, understood and appreciated that the doctor and his medical society are always working for the best interest of the individual who is or may become a patient.

4. Your committee proposes to encourage coordination between it and the other committees and commissions within the C.M.A. structure at state level with the hope that the public relations program of the C.M.A. may be a means whereby their good performance will be better understood and appreciated by the profession, by our patients, and the public.

These then, with your approval, are your PR Committee objectives for the coming year.

ACTION ON RESOLUTIONS

A total of 77 resolutions was introduced before the 1959 House of Delegates, exclusive of proposed amendments to the Constitution and By-Laws and emergency measures. These resolutions are shown here in serial form, together with the action taken on each and, where appropriate, excerpts from pertinent remarks made by the reference committees in bringing the resolutions to the floor for vote.

Several resolutions were withdrawn by their authors. Where this was done, this listing simply shows

the number of the resolution and the fact that it was withdrawn.

Where reference committees combined two or more resolutions into one substitute which was then adopted, the number of the earliest resolution is shown as the one on which action was taken and note made of the numbers of subsequent resolutions which were combined with it; the later resolutions are marked to show that they were combined with an earlier number.

* * *

DISSEMINATION OF MEDICAL NEWS

Resolution No. 1.

ACTION: Withdrawn by author.

* * *

JUDICIAL COMMISSION

Resolutions No. 2 and No. 55 were combined by the reference committee under a substitute resolution reading as follows:

Resolved: That the proposals contained in Resolutions No. 2 and No. 55 be referred to the Constitution Study Committee for its consideration and for the drafting and introduction of By-Law amendments deemed appropriate by that committee.

ACTION: Adopted by House.

Resolutions No. 2 and No. 55 are shown here for their content.

Resolution No. 2.
Author: Wm. H. Wickett, Jr.
Representing: Orange County Medical Society.

WHEREAS, local county Judicial Councils are, without exception, made up of extremely capable and experienced senior members of local county societies; and

WHEREAS, any hearings on charges of unprofessional conduct are heard by these local Judicial Councils which are well acquainted with the local situation and customs; and

WHEREAS, these hearings are conducted without prejudice and according to specific procedures stipulated by the California Medical Association before an impartial referee; and

WHEREAS, county punitive decisions have been reversed by the California Medical Association Judicial Commission when appealed thereto; now, therefore, be it hereby

Resolved: That the Council of the California Medical Association refer to a special or regular committee to study the functions of the body known as the Judicial Commission, with the purpose of more strongly considering and supporting the opinions of local county Judicial Councils.

Resolution No. 55.
Author: Dudley Bell.
Representing: Eighth District.

WHEREAS, Section 3, Chapter 3, of the By-Laws of the California Medical Association should be amended to provide that the Judicial Commission of the California Medical Association, when hearing appeals by a member from a decision taken by a county medical association Judicial Council against a member, be limited in its consideration to establishing that the proper procedure for disciplinary action has been followed by the county medical association Judicial Council; to the determination that no membership rights or civil rights of the accused have been violated by the county medical association Judicial Council; and to the determination that the accused member has been afforded an adequate opportunity to defend himself against the charges; and

WHEREAS, the above section and chapter should be further amended to provide that the Judicial Commission of the California Medical Association may affirm or reverse the decision of the county medical association Judicial Council on the basis of the above considerations only; but that it may not modify, reduce or increase the penalty imposed upon the member by the county medical association Judicial Council; and

WHEREAS, the above section and chapter should be further amended to provide that, in the event the California Medical Association Judicial Commission reverses the decision of a county medical association Judicial Council on the basis of the above considerations, that the Judicial Council of the county medical association may reinstitute proceedings against the accused member; now, therefore, be it

Resolved: That this proposal be referred to the Constitution Study Committee for its consideration, and for the drafting and introduction of By-Law amendments deemed appropriate by that committee.

* * *

SOCIALIZED MEDICINE

Resolution No. 3.
Author: Richard Boylan.
Representing: Riverside County Medical Association.

WHEREAS, it is alleged that socialized medicine in England has produced, among other things, the following results:

1. Increased cost of medicine;

2. Deprived the general practitioner of access to hospitals;

3. Admission to hospitals is delayed sometimes for as much as two years;

4. Produces panels of large size, e.g., 3,600, and

an individual practitioner will see from 90 to 110 patients per day in his office;

5. Encourages symptomatic medicine resulting in a deterioration of both the quality and accuracy of work;

6. Aggravates hypochondriasis;

7. Discourages the student from entering medical school;

8. Results in an undue amount of paper work; and

WHEREAS, there is an increasing tendency toward socialized medicine in the United States and in the several states of the Union through various security programs; and

WHEREAS, there is the same tendency within labor unions to bring about controlled medicine for the benefit of their own large groups of members; and

WHEREAS, there is an increasing tendency on the part of practitioners in America who have, through their several associations pledged themselves not to participate in government programs, do nonetheless participate in those programs; and

WHEREAS, it would be of enormous benefit to every doctor and every association in the United States to understand more fully the causes for socialized medicine in England, as well as the events, personalities and practices which triggered the system into being, and to study those mistakes which were made and might have been avoided in setting up the system which they now have in England; now, therefore, be it

Resolved: That the delegates of the California Medical Association to the American Medical Association be instructed to request the A.M.A. to create, finance and sponsor forthwith a study group which will thoroughly explore the history, causes and results of socialized medicine in England, and that such representatives be professionals in the field of investigating such institutions with the objective of rendering a factual and objective report.

ACTION: Referred to delegates to the A.M.A.

(Comment by Reference Committee No. 3: "Evidence was presented that these data might well have been previously covered by interested committees and commissions and may now be available. . . .")

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MEDICAL CARE FOR THE AGED

Resolution No. 4.

Author: William H. Wickett, Jr.

Representing: Orange County Medical Society.

Resolutions No. 44 and No. 54 combined and the following substitute resolution presented by Reference Committee No. 3:

Resolved:

1. That this House instruct the Council of the C.M.A. and C.P.S. to proceed with all speed to develop and actively sell voluntary health plans to further expedite the health care of the aging;

2. That funds from C.M.A. reserves or in the form of additional levies on the membership be used if necessary in promoting this program in its experimental phase;

3. That C.P.S. Trustees also be requested to allocate reserve funds in amounts to be determined for this purpose;

4. That it approves the contract terms that Board of Trustees has adopted as previously stated in this report;

5. That appropriate progress reports be periodically forwarded to the members of the House of Delegates throughout the ensuing year.

ACTION: Adopted by House.

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ALTERNATE DELEGATES

Resolution No. 5.

ACTION: Withdrawn by author.

* * *

DISTRICTING OF C.M.A.

Resolution No. 6.

Authors: J. B. Price and L. E. Wilson.

Representing: Orange County Medical Society.

WHEREAS, there is a continuing doctor population growth, more marked in certain regions of California than in others; and

WHEREAS, there are many other regional changes such as agricultural areas becoming industrial areas; and

WHEREAS, the Council of the California Medical Association has recently reactivated a special committee to study redistricting of the California Medical Association; now, therefore, be it hereby

Resolved: That the Council of the California Medical Association have the special redistricting committee meet at least twice during 1959, once in the northern area and once in the southern area, at which meetings the individual county medical societies of those areas will be invited to send representatives to discuss their own particular problems relating to districting of the California Medical Association; and be it further

Resolved: That such meetings be held prior to any decisions being made as to the feasibility of adopting the redistricting as outlined in the Heller report.

ACTION: Referred to Constitution Study Committee.

COVERAGE FOR SENIOR PHYSICIANS

Resolution No. 7.
Author: Edgar Wayburn.
Representing: San Francisco Medical Society.

WHEREAS, at the present time there is no provision for senior physicians (over 65) in the medical profession's catastrophic and medical insurance plans; and

WHEREAS, it is desirable and fitting for the medical profession to provide for its senior colleagues; now, therefore, be it

Resolved: That the C.M.A. direct its appropriate committee to investigate inclusion of the senior physicians in such plans.

ACTION: Adopted by House.

UNSCIENTIFIC SURVEYS

Resolution No. 8.
Author: Edgar Wayburn.
Representing: San Francisco Medical Society.

WHEREAS, certain commercial so-called research associations conduct surveys among the medical profession on use of certain products; and

WHEREAS, these surveys consist of small, unscientific samplings which are misleadingly publicized as being accurate, thorough and clinically proven; now, therefore, be it

Resolved: That the C.M.A. go on record as condemning such surveys as being not in the public interest; and be it further

Resolved: That a similar resolution be introduced by the C.M.A. to the A.M.A.

ACTION: Adopted by House.

UNIFORM SYSTEM OF PAYMENT

Resolution No. 9.

ACTION: Not adopted by House.

IDENTIFICATION OF PAYMENT METHOD

Resolution No. 10.

ACTION: Withdrawn by author.

PUBLIC ASSISTANCE PROGRAMS

Resolution No. 11.

ACTION: Withdrawn by author.

DOCTOR-PATIENT RELATIONSHIPS

Resolution No. 12.
Authors: Delegates of First District.
Representing: First C.M.A. District.

WHEREAS, the continued interjection of a third party in the doctor-patient relationship is inevitable; and

WHEREAS, the administrative demands made by such third parties impose an ever-increasing burden on the physician's time, jeopardizing his ability to properly carry out his professional responsibilities to his patients; now, therefore, be it

Resolved: That this House of Delegates establish the policy that a physician's obligations go no further than appropriate medical care; a properly itemized statement of fees; and a single, standard physician's report; and, further, be it

Resolved: That requested additional reports or professional opinions constitute a separate service which the physician may render, at his own discretion, for an appropriate fee.

ACTION: Adopted by House.

DETERMINATION OF THE COST OF PRACTICING MEDICINE

Resolution No. 13.
Authors: Delegates of First District.
Representing: First C.M.A. District.

WHEREAS, the continued interjection of a third party in the doctor-patient relationship is inevitable; and

WHEREAS, these third parties have in the past, of necessity, based their fee schedules on opinion surveys since no effort has been made to obtain a factual knowledge of the actual cost of practicing medicine; now, therefore, be it

Resolved: That this House of Delegates instruct the Council to refer the problem of medical practice cost accounting principles to the proposed Bureau of Research and Planning.

ACTION: Adopted by House. (The "Resolved" portion above was substituted by the reference committee for the original proposal.)

PREPAID HEALTH AND MEDICAL CARE COSTS

Resolution No. 14.
Authors: Delegates of First District.
Representing: First C.M.A. District.

WHEREAS, the cost of prepaid health insurance has increased materially throughout the last several years; and

WHEREAS, in the public mind the cost of medical fees is often loosely blamed as the cause of this increased cost; and

WHEREAS, the bulk of such increased costs are due to increased utilization and cost, particularly of hospital beds and other ancillary services; now, therefore, be it

Resolved: That the California Medical Association shall use whatever means are available to it to accomplish the end that in all health insurance, pre-

paid medical care plans, or other types of health coverage, the cost of professional services shall be clearly designated in the premium charge as separate and distinct from the cost of hospitalization and other ancillary services.

ACTION: Adopted by House.

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INSURANCE REPORT FEES

Resolution No. 15.
Authors: Delegates of First District.
Representing: First C.M.A. District.

WHEREAS, insurance companies in personal injury cases are obtaining the information necessary from the attending physician for the settlement of claims; and

WHEREAS, insurance companies often accomplish this without cost by presenting the injured, who is not their insured, with an insurance form to be completed by the injured's physician; and

WHEREAS, the insurance companies by submission of the request through the injured avoid the liability for payment of an opinion, and many times an expert opinion, necessary in the settlement of the claim; now, therefore, be it

Resolved: That the House of Delegates endorse the principle of an equitable fee for the preparation of these reports to permit the Committee on Fees to include this item in the Relative Value Study or by any other method of implementation within the California Medical Association structure.

ACTION: Adopted by House.

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SOCIAL SECURITY COVERAGE FOR PHYSICIANS

Resolution No. 16.
Author: John B. Hamilton.
Representing: Los Angeles County Delegate.

Resolutions No. 34 and No. 41 were combined with Resolution No. 16 by the reference committee and a substitute resolution presented to the House, as follows:

WHEREAS, Social Security coverage for physicians is controversial; and

WHEREAS, legally elected officers and delegates are desirous of informed educated opinion from their constituents; and

WHEREAS, these matters are most equitably handled on a local rather than statewide basis; now, therefore, be it

Resolved: That—

1. Each county society institute an educational program with a poll of its membership re social security coverage, the format of which should be submitted by the Council to each individual society in the interest of uniformity; and

2. That the Speaker appoint a special committee of the House of Delegates composed of proponents and opponents of this subject, whose duties shall be (a) the development of the format for a standard poll on social security for the State of California; (b) that this committee secure the consultation of the C.M.A. Council in the formation of this format; and (c) that the committee make this material available to the component county medical societies for their use.

ACTION: Adopted by House.

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PROPOSED LEGISLATION RE TUBERCULOSIS TESTS FOR SCHOOL EMPLOYEES

Resolution No. 17.
Author: Edgar F. Mauer.
Representing: L.A.C.M.A. delegation.

WHEREAS, it is in the public interest to require school teachers to have regular chest x-rays as a public health measure to prevent the spread of this disease among school children, and by them to others; and

WHEREAS, conflicting interpretations of existing state law have confused school boards, teachers, and others in what their responsibilities are in this important matter; therefore, be it

Resolved: That an appropriate amendment to the Educational Code of the State of California be introduced at the current meeting of the State Legislature. Such amendment shall require without exemption that all employees of any school district undergo an examination to determine that they are free of active tuberculosis. Such examination shall be conducted by a physician and surgeon licensed by the State of California, and shall consist of an x-ray of the lungs, or an approved tuberculin skin test which, if positive, shall be followed by an x-ray of the chest.

Pending passage of such legislation, all school districts should be urged to follow this procedure.

ACTION: Adopted by House. (Minor amendment in language proposed by reference committee and approved.)

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PUBLIC RELATIONS ORGANIZATION FOR PRIVATE MEDICINE VS. GOVERNMENT MEDICINE

Resolution No. 18.
Author: Douglas Donath.
Representing: L.A.C.M.A. delegation.

WHEREAS, progressive encroachment upon the private practice of medicine is taking place in spite of current efforts to preserve it; and

WHEREAS, very little effective information to and education of the public has been accomplished relating to the excellent quality and availability of American medicine as compared with that in socialized states; and

WHEREAS, the most effective appeal to legislators is through their constituents at the so-called "grass roots" level; and

WHEREAS, a real emergency exists as a threat to the private practice of medicine being destroyed, as illustrated by the recent political action taken in the State of California and elsewhere, together with the predicted legislation to be passed soon at the national level; and

WHEREAS, the most effective means must be used to reach the public and legislators without delay; and

WHEREAS, every effort must be brought to bear to encourage the passage of legislation favorable to the preservation of the private practice of medicine without government influence or domination, and to prevent the passage of legislation which encourages government participation or control of medicine; and

WHEREAS, the cost of such a program would involve considerable expenditure of funds; therefore, be it

Resolved: That—

1. The Council of the C.M.A. be charged with the duty to obtain without delay, the services of a public relations organization of recognized ability and standing, whose duties shall be:

(a) To educate the public as to the benefits the public derives from the excellence of private medicine in the United States of America as compared to government medicine elsewhere;

(b) To create "grass roots" interest and appreciation for private medicine;

(c) To encourage the passage of legislation favorable to the private practice of medicine;

(d) To discourage the passage of legislation which favors government influence, domination or control of medicine.

2. The Council of the C.M.A. be given endorsement to levy a reasonable assessment on its membership to finance the program if available funds are insufficient;

3. The delegates to the A.M.A. from California be instructed to introduce and make every possible effort to insure passage of a similar resolution at the next meeting of the A.M.A.

ACTION: Referred to Commision on Public Policy for consideration and report to the Council.

C.M.A. RELATIVE VALUE STUDY PAMPHLET

Resolution No. 19.
Author: Douglas Donath.
Representing: L.A.C.M.A. delegation.

WHEREAS, the C.M.A. Relative Value Study pamphlet is a relative study of fees as stated, and in no way represents a fixed fee schedule; therefore be it

Resolved: That the C.M.A. reaffirm its position that the Relative Value Study pamphlet cannot be used as a fixed fee schedule; and, further, be it

Resolved: That this principle be always clearly and explicitly incorporated into the "Foreword and Preface" of the C.M.A. Relative Value Study pamphlet.

ACTION: Adopted by House.

FREE CHOICE OF PHYSICIAN

Resolution No. 20.

ACTION: Withdrawn by author.

HEALTH INSURANCE TERMS

Resolution No. 21.
Author: John M. Rumsey.
Representing: San Diego County Medical Society.

WHEREAS, the so-called "medical while hospitalized" type of insurance has resulted in increased pressure on doctors for hospitalization by patients; and

WHEREAS, it seems to us that this creates an "attractive nuisance"; and

WHEREAS, this "attractive nuisance" stimulates the hospitalization of patients for procedures which could more economically be done in the office; now, therefore, be it

Resolved: That the California Medical Association use whatever means it can to stimulate the writing of insurance so that the procedure or disease is specifically noted, rather than the place—that is, hospital or office where this is cared for or done—as the basis for coverage.

ACTION: Adopted by House.

FOREIGN GRADUATES

Resolution No. 22.

ACTION: Withdrawn by author.

NEW C.P.S. COVERAGE

Resolution No. 23.
Author: Samuel Hurwitz.
Representing: San Francisco Medical Society.

WHEREAS, C.P.S. has recently made available benefits for the newborn and premature infant; and

WHEREAS, this fills a long standing need and should prove valuable to both physicians and patients; now, therefore, be it

Resolved: That the House of Delegates of the California Medical Association commend C.P.S. for this forward step and instruct it to give the widest possible publicity to these benefits so that subscribing members will be encouraged to obtain this coverage.

ACTION: Adopted by House.

* * *

A.M.A. COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

Resolution No. 24.
Author: A. B. Sirbu.
Representing: San Francisco Medical Society.

WHEREAS, the A.M.A. Council on Medical Education and Hospitals is designed to aid, increase and encourage the opportunity for better medical education, rather than hinder its development by punitive measures; and

WHEREAS, under the existing method of hospital intern training program approval the report of one individual to a subcommittee of the A.M.A. Council on Medical Education and Hospitals can determine the approval or rejection of a hospital training program; and

WHEREAS, unlike the Commission on Accreditation of Hospitals, under the existing structure of the A.M.A. Council on Medical Education and Hospitals there is no mechanism for appeal by a hospital staff from what could be an arbitrary or even erroneous evaluation by a single individual; and

WHEREAS, abrupt withdrawal of approval of training programs has been disruptive and harmful; and

WHEREAS, in 1956 and 1957 the C.M.A. was presented with resolutions suggesting revisions in the approval methods of the Council on Medical Education; and

WHEREAS, this body went on record as approving these revisions and there has been no evidence of change through the Council on Medical Education and Hospitals; now, therefore, be it

Resolved: That the C.M.A. House of Delegates instruct our delegates to the A.M.A. and also notify the component societies of California and other states that the following be implemented:

1. When a hospital training program has received a recommendation of disapproval from an A.M.A. Council inspector that hospital shall be given written notification of the deficiencies prior to definitive action on the report by the A.M.A. Council on Medical Education and Hospitals.

2. The inspected hospital if it so desires shall be granted a prescribed time to prepare a rebuttal to the report of the inspector. This report, together with the inspector's shall be considered by a regional committee which, where indicated, shall make a personal investigation of the facts. The regional committee shall then send its own recommendation to the Council on Medical Education and Hospitals.

3. That minimum standards in *Essentials of an Approved Internship* last published in 1955 be carefully reviewed and adequately clarified so that each hospital may find a detailed and lucid description of minimum requirements for approval.

ACTION: Adopted by House.

* * *

HEALTH INSURANCE PLANS

Resolution No. 25.

ACTION: Withdrawn by author.

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PUBLIC ASSISTANCE FEE SCHEDULE

Resolution No. 26.
Author: Emmet Rixford.
Representing: San Francisco Medical Society.

WHEREAS, changes in the present fee schedule of the Public Assistance program are inevitable; now, therefore, be it

Resolved: That in negotiations for revision of the Public Assistance program fee schedules the most recent relative value study be used and the current factor for the average income group be considered.

ACTION: Adopted by House.

* * *

COMMISSION ON PERSONAL INJURIES

Resolution No. 27.
Author: Charles A. Noble.
Representing: San Francisco Medical Society.

WHEREAS, the C.M.A. House of Delegates in the past has been interested in plans for an impartial state administered commission on personal injuries; and

WHEREAS, Governor Edmund G. Brown has announced his interest in an impartial commission similar to the Industrial Accident Commission for use in all automobile personal injury cases; now, therefore, be it

Resolved: That this House of Delegates reaffirm its interest in the principle of such commissions for the administration of impartial justice to the injured citizen and refer this to the C.M.A. Council for imdiate investigation and action; and be it further

Resolved: That the Governor be informed of the C.M.A.'s action.

ACTION: Adopted by House.

* * *

AIR POLLUTION

Resolution No. 28.
Author: Grace M. Talbott.
Representing: San Francisco Medical Society.

WHEREAS, evidence is accumulating that air pollution, including both radioactive and nonradioactive contaminants, is detrimental to the health and welfare of the people of California; and

WHEREAS, this is a problem which is increasing progressively in magnitude throughout the state; and

WHEREAS, the medical profession is vitally concerned with such problems; now, therefore, be it

Resolved: That the C.M.A. include in its Commission on Public Health and Public Agencies a committee on air pollution to consist of physicians who are authorities in this field, the functions of said committee to include stimulation of and sponsorship of research in all phases of atmospheric contamination in our state; and be it further

Resolved: That the C.M.A. should offer the services of this committee to the State of California and all its counties, municipalities, and other public agencies.

ACTION: Adopted by House.

* * *

EXFOLIATIVE CYTOLOGY

Resolution No. 29.
Author: T. D. Englehorn.
Representing: Monterey County Medical Society.

WHEREAS, exfoliative cytology is a phase of pathologic histology and as such constitutes a portion of the practice of medicine; and

WHEREAS, interpretation of exfoliative cytology smears is a medical consultation which is or should be performed by a qualified Doctor of Medicine for a second Doctor of Medicine; and

WHEREAS, the billing of one physician by a second physician for services performed on a patient hinders the physician-patient relationship and lays the groundwork for the development of fee splitting and kickbacks either apparent or concealed; and

WHEREAS, such billing practices are not in the best interests of the patient; now, therefore, be it

Resolved:

1. That consultations in exfoliative cytology be subject to the ethical precepts required of all other medical consultations.

2. That this House of Delegates recommend to the C.M.A. Council that it cause to be published for the information of all C.M.A. members (a) the ethical principles applicable to medical consultations and (b) the laws of the State of California which prohibit fee splitting and kickbacks regardless of whether they are apparent, concealed or implied.

ACTION: Adopted by House.

* * *

CARE FOR THE AGED

Resolution No. 30.
Author: Edward Liston.
Representing: Santa Clara County Medical Society.

WHEREAS, the medical profession in the past has chosen freely to accept special arrangements for the treatment and care of certain groups, such as the indigent, crippled children, the clergy, the blind, military dependents, patients suffering from tuberculosis or venereal disease and other such categories; and

WHEREAS, these special arrangements have been accepted by the free choice of the medical profession acting as free men; and

WHEREAS, the needy aged constitute a group requiring special arrangements for their medical care; now therefore, be it

Resolved: That the medical profession of California continue its efforts to develop plans for the medical care of the needy aged as a special group, and that all such plans for their special care should be subject to the free choice of free men and should not be dictated by political power.

ACTION: Adopted by House.

* * *

"UNIT VALUE" SURVEYS

Resolution No. 31.

ACTION: Not adopted by House.

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C.P.S. EMERGENCY SERVICE PAYMENTS

Resolution No. 32.
Author: Warren L. Bostick.
Representing: Ninth Councilor District.

Resolution No. 33 combined with No. 32 by C.P.S. Reference Committee and following substitute resolution offered:

Resolved: That the House of Delegates request the Board of Trustees of the C.P.S. to appoint a committee composed of physicians not employed by C.P.S. to review the general situation of the diversion and payments to hospitals of procedures and facilities that can be provided in the office of the private physician to his justified benefit; and be it further

Resolved: That if this study committee finds it feasible, that the C.P.S. Fee Schedule include a tray fee in doctors' offices for surgery and this fee be on the same basis as tray fees paid hospitals for the same procedure; and be it further

Resolved: That the Board of Trustees, acting with the advice of said committee, is requested to report its conclusions and recommendation regarding these problems to the House of Delegates at the next Annual Meeting.

ACTION: Adopted by House.

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Resolution No. 33—See Resolution No. 32.

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Resolution No. 34—See Resolution No. 16.

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NURSES' TRAINING PROGRAMS

Resolution No. 35.
Author: Leon P. Fox.
Representing: Santa Clara County Medical Society.

WHEREAS, previous attempts, by individuals, to inform and interest California physicians in the present day trend of nursing education, have been practically futile; and

WHEREAS, efforts of this House by previous resolutions to effect stronger representation on Advisory Committees of Nursing Education Organization at state and national level for the purpose of improving curriculums and patient care instruction, from the physicians' standpoint, have accomplished very little (note pre-convention report of Committee on Other Professions); and

WHEREAS, the Santa Clara County Medical Society has been able to acquire stronger local physician representation, on the two-year Junior College Program Advisory Committee, and is endeavoring to similarly participate actively in the four-year Collegiate and three-year Diploma Hospital Programs; now, therefore, be it

Resolved: That the Council through its district members direct all component societies to initiate effective physician participation at the grass roots level in all new or proposed nurse education programs for the purpose of improving the nurse graduate of the future; and be it further

Resolved: That the Council continue its efforts more aggressively, to effect enlightened physician representation on Advisory Boards to Nursing Education and licensing organizations at the state level; and be it further

Resolved: That the Delegates to the A.M.A. from the C.M.A. be directed to act similarly at the national level.

ACTION: Adopted by House.

SPECIALISTS AS ADVISORS

Resolution No. 36.

ACTION: Withdrawn by author.

* * *

TAXATION

Resolution No. 37.
Author: Roberta Fenlon.
Representing: San Francisco Medical Society.

WHEREAS, many health plans advanced by legislators are described as covered by "federal aid"; and

WHEREAS, "federal aid" money comes from the taxpayers of America and not from supposedly unlimited government coffers; and

WHEREAS, the growing entry of government into medicine adds to the already heavy tax burden of American citizens; now, therefore, be it

Resolved: That the C.M.A. Public Relations Committee be instructed to prepare factual information for dissemination on the cost of government financed medical care as it affects each individual taxpayer.

ACTION: Adopted by House.

* * *

ANNUAL MEETING DATES

Resolution No. 38.
Author: Edgar A. Wayburn.
Representing: San Francisco Medical Society.

Resolution No. 71 was combined by the reference committee with Resolution No. 38 and the following substitute offered:

Resolved: That the C.M.A. return as nearly as possible to its usual meeting time, and this return be effective as soon as feasible; and be it further

Resolved: That our delegation to the A.M.A. seek the appointment of a committee to plan the integration of all medical meetings in a manner to minimize conflict of meeting dates.

ACTION: Adopted by House.

* * *

POSTGRADUATE TEACHING COURSES

Resolution No. 39.
Author: Edgar Wayburn.
Representing: San Francisco Medical Society.

WHEREAS, the present system of postgraduate education at C.M.A. conventions prevents the participation of the membership in both the scientific and business sessions; and

WHEREAS, the attendance and caliber of the scientific sessions should be increased in accord with the size and prestige of the C.M.A.; now, therefore, be it

Resolved: That the C.M.A. Committee on Scientific Work be requested to schedule any postgraduate teaching courses so they will least conflict with the scientific or business sessions of the C.M.A.

ACTION: Adopted by House.

* * *

RELATIVE VALUE UNITS BY AREA

Resolution No. 40.
Author: Edgar Wayburn.
Representing: San Francisco Medical Society.

WHEREAS, it is impractical for insurance plans to bargain for fees on county levels; and

WHEREAS, figures for average charges in various counties are available; and

WHEREAS, there are fee variations in various urban and rural areas; now, therefore, be it

Resolved: That the C.M.A. Council study the desirability and feasibility of amending the relative value study to develop relative values of units for appropriate areas in the state.

ACTION: Referred to Commission on Medical Services for further consideration.

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Resolution No. 41—See Resolution No. 16.

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HEALING ARTS LICENSURE

Resolution No. 42.
Author: Dudley Bell.
Representing: Eighth District.

WHEREAS, Assembly Bill 827, which would create a Division of Healing Arts separating such arts from the trades within the Department of Professional and Vocational Standards, includes optometry; and

WHEREAS, optometry is defined by the California Business and Professions Code (Div. 2, Ch. 7, Art. 3, Sec. 3041) as ". . . the employment of any means other than the use of drugs for the measurement of the powers or range of human vision or the determination of the accommodative and refractive states of the human eye or the scope of its functions in general or the adaption of lenses or frames for the aid thereof"; and

WHEREAS, optometry is limited by this code to the measuring of the eye and to the fitting and sale of glasses; now, therefore, be it

Resolved: That the C.M.A. state its opposition to the inclusion of a nonhealing, nonmedically related vocation in the Division of Healing Arts as proposed by Assembly Bill 827.

ACTION: Referred to Committee on Legislation.

PUBLIC ASSISTANCE MEDICAL CARE PROGRAM

Resolution No. 43.
Author: Dudley Bell.
Representing: Eighth District.

WHEREAS, the recently enacted Public Assistance Medical Care Program is administratively unwieldy and costly; and

WHEREAS, the necessary rules of the State Social Welfare Department in administering the Act are complex and difficult of interpretation by doctor or patient, causing reluctance on the part of the doctor to involve himself in the paperwork and restrictions incident to the program and causing confusion and frustration in the patient; now, therefore, be it

Resolved: That the California Medical Association urges that the money made available by federal and state governments under this program for the provision of medical care to indigent persons of various classes be used instead for the purchase of health insurance from California Physicians' Service, such insurance program to be designed by members of the California Medical Association in consultation with the State Social Welfare Department, in order to provide for these patients the maximum amount of medical care which can be purchased for the dollar expended and in order to eliminate as far as possible costly administrative procedures presently necessary in the resolution.

ACTION: Referred to Commission on Medical Services for further consideration.

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Resolution No. 44—See Resolution No. 4.

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C.M.A. DEPARTMENT OF NEGOTIATIONS

Resolution No. 45.
Author: Wm. H. Thompson.
Representing: San Mateo County Medical Society.

WHEREAS, in 1957 this House of Delegates passed Resolution No. 9 concerning the development of a department within the C.M.A. for the purpose of negotiating with representatives of groups wishing to provide medical care to private citizens of the state; and

WHEREAS, in 1958 this House of Delegates passed a substitute resolution for resolutions Nos. 25, 30 and 64 directing the Council to expedite formation of such a department to study specified problems; and

WHEREAS, such a department will be unable to properly negotiate without a fee schedule approved and supported by this House of Delegates; and

WHEREAS, in order to receive wide approval of the members of the C.M.A. such a fee schedule must

allow for a certain degree of local control and geographic variation of fees; now, therefore, be it

Resolved: That the C.M.A. Council take immediate steps to expedite the development of such a department as previously directed by this House of Delegates by resolutions in 1957 and 1958; and be it further

Resolved: That the immediate concern of this department is the study of the feasibility and advisability of the development of a fee schedule for negotiating purposes under the following basic principles:

1. In cooperation with local county medical societies a dollar unit value shall be determined for each of the various county societies.

2. This dollar unit value shall be determined with the approval of each local county medical society and after consideration of the variations of cost of medical practice and other factors which determine the variation of fees in different geographic areas.

3. These various fee schedules may be weighted and combined into a single fee schedule for negotiating purposes.

4. These various fee schedules or the combined fee schedules shall be the only basis on which the C.M.A. shall negotiate fees for medical services provided by its members.

5. These fee schedules may be reduced for certain classifications of patients as authorized by the House of Delegates.

and be it further

Resolved: That the Council of the C.M.A. be directed to report the findings of this department and Council recommendations on these findings to the next House of Delegates.

ACTION: Referred to the Council.

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C.M.A. COMMITTEE APPOINTMENTS

Resolution No. 46.
Author: William H. Thompson.
Representing: San Mateo County Medical Society.

WHEREAS, the preponderance of C.M.A. committee members are presently from Los Angeles and San Francisco; and

WHEREAS, some of the smaller county medical societies are not adequately represented on C.M.A. committees and should now receive an increased representation in view of their increasing relative size; and

WHEREAS, this House of Delegates believes that C.M.A. committee appointments should be made only after consideration of reasonable geographic and proportionate representation, the availability of interested, qualified members and a policy of rotation of members through committees; now, therefore, be it

Resolved: That this House of Delegates instruct the Council to initiate a definitive policy regarding committee appointments to include the following principles:

1. New appointments to committees shall be made only after due consideration of a member's interest, ability, qualification and recommendations and with reasonable consideration of overall geographic and proportionate representation.

2. Committee appointments shall not be made on an honorary basis.

ACTION: Adopted by House after one "Resolved" section that would have limited appointees to two consecutive terms had been deleted on recommendation of the reference committee.

* * *

GOVERNMENT PROVISION OF MEDICAL SERVICES

Resolution No. 47.
Author: Wm. H. Thompson.
Representing: San Mateo County Medical Society.

WHEREAS, legislation concerning medical services is often worded to the effect of "providing medical services" although the intent of the legislation is to provide for payment or reimbursement of medical services; and

WHEREAS, it is in the public interest that it be informed that it is the medical profession and not government agencies which provides medical services; now, therefore, be it

Resolved: That the C.M.A. actively oppose the inclusion of wording in any legislation which, in effect, provides medical services for any group of persons, and, be it further

Resolved: That the C.M.A. expand every effort to revise the wording of legislative acts to the effect of providing for payment or reimbursement of medical expenses; and be it further

Resolved: That the C.M.A. delegates to the A.M.A. submit a similar resolution to the A.M.A. House of Delegates.

ACTION: Adopted by House in above form, which represents an amendment in the second "Whereas" from the original introduction.

* * *

SEGREGATION OF FUNDS

Resolution No. 48.
Author: Wm. H. Thompson.
Representing: San Mateo County Medical Society.

WHEREAS, legislation providing funds for medical services usually does not specify the amount or proportion of the funds to be used for physician and

dentist services as opposed to drugs, nursing care, hospitalization, etc. and

WHEREAS, this policy is actuarially unsound and violates good business principles; and

WHEREAS, this policy leads to the false impression by the public that the high cost of medical care is largely due to the cost of these services; now, therefore, be it

Resolved: That the C.M.A. forcibly bring to the attention of legislative representatives the importance of segregation of funds for physician and dentist services from funds for drugs, nursing care, hospitalization etc., and be it further

Resolved: That the C.M.A. work to incorporate this policy of segregation of funds into any legislation which does not specify the amount or portion of funds for physician and dentist services; and be it further

Resolved: That the C.M.A. delegates to the A.M.A. submit a similar resolution to the next A.M.A. House of Delegates.

ACTION: Adopted by House in above form, which was amended from original introduction on motion by the reference committee.

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INSURANCE INCLUSION OF CONSULTATION

Resolution No. 49.
Author: Dudley Bell.
Representing: Eighth District.

WHEREAS, the consultation is not only desirable but often required as an integral part of patient care; and

WHEREAS, Blue Cross and other health insurance carriers do not provide their members with coverage for this necessary medical service; and

WHEREAS, the consultation is an insurable risk as demonstrated by its inclusion in recent C.P.S. contracts; now, therefore, be it

Resolved: That the C.M.A. strongly urge Blue Cross and other health insurance carriers to include coverage for the consultation in their health insurance contracts.

ACTION: Adopted by House.

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INSURANCE INCLUSION OF DIAGNOSTIC STUDY

Resolution No. 50.
Author: Dudley Bell.
Representing: Eighth District.

WHEREAS, the diagnostic study is a recognized procedure and valuable in patient care; and

WHEREAS, such procedure is expressly excluded from some health insurance contracts offered by C.P.S. and Blue Cross; and

WHEREAS, such exclusion can impose major expense upon patients having health insurance and impose limitations on the physician's care of such patients; and

WHEREAS, the diagnostic study is an insurable risk; now, therefore, be it

Resolved: That the C.M.A. urge all health insurance carriers to include the diagnostic study in future contract offerings.

ACTION: Referred to Commission on Medical Services.

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A.M.A. DUES "TODAY'S HEALTH"

Resolution No. 51.
Author: Gerald W. Shaw.
Representing: Los Angeles County Medical Association.

WHEREAS, the membership dues to the American Medical Association includes a subscription to the *Journal of the American Medical Association;* and

WHEREAS, the magazine *Today's Health* is also a publication of the American Medical Association, which is a valuable asset for the member's reception room; and

WHEREAS, subscription to *Today's Health* is not included as part of the American Medical Association dues; now, therefore, be it

Resolved: That the House of Delegates encourage its delegates to the A.M.A. to introduce a resolution encouraging every physician member to have *Today's Health* in his home and office.

ACTION: Adopted by House in above form, which was amended from the original introduction on recommendation of the reference committee.

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UNPROFESSIONAL CONDUCT

Resolution No. 52.

ACTION: Withdrawn by author.

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UNPROFESSIONAL CONDUCT—DEFINITION

Resolution No. 53.
Author: William F. Quinn.
Representing: Los Angeles County Medical Association.

WHEREAS, the prescribing of so-called dangerous drugs, as defined in the Pharmacy Code, by a few physicians without a prior examination of the patient or medical indication, constitutes a problem to law enforcement agencies; and

WHEREAS, the Business and Professions Code is vague in its definition of this phase of unprofessional conduct; now, therefore, be it

Resolved: That the California Medical Association direct its Council to initiate legislation to amend the code to the effect that:

Prescribing of so-called dangerous drugs, as defined in the Pharmacy Code, without a prior examination of the patient or medical indications therefor, shall constitute unprofessional conduct.

ACTION: Adopted by House in above form, which was amended from original introduction on recommendation of the reference committee.

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Resolution No. 54—See Resolution No. 4.

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Resolution No. 55—See Resolution No. 2.

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PROPOSED DEPARTMENT OF PUBLIC HEALTH

Resolution No. 56.
Author: Warren A. Wilson.
Representing: Los Angeles County Medical Association.

WHEREAS, legislation is now underway in California to transfer certain boards of licensure from the Bureau of Professional and Vocational Standards into a new Division of Healing Arts to be administered by the State Department of Public Health under which will probably be placed the Board of Medical Examiners; and

WHEREAS, the Board of Optometric Examiners was one of the first to propose transfer to the new division; and

WHEREAS, the inclusion of the new optometrists under a Healing Arts Board will further the persistent organized and well financed national attempt on the part of optometrists to present themselves to the public as the group primarily responsible to the public for eye care and further their avowed intent to make visual care the exclusive field of optometry by legislation as soon as possible, excluding all exceptions; and

WHEREAS, it is not in the public interest that the public should believe that optometrists are qualified to diagnose and treat such sight destroying diseases as glaucoma; and

WHEREAS, all such attempts to blur the distinction between the refraction technician or optometrist and the medical specialist or ophthalmologist are an attempt to enter the practice of medicine by legislation rather than by education; now, therefore, be it

Resolved: That the Los Angeles Society of Ophthalmology and Otolaryngology and the Long Beach Eye, Ear, Nose and Throat Society request the House of Delegates of the C.M.A. to express its opposition to inclusion of the Board of Optometric Examiners under a Division of Healing Arts and requests the legislative representatives of the California Medical Association to oppose such action as not being in the public interest.

ACTION: Referred to Committee on Legislation.

RADIATION HAZARD

Resolution No. 57.

ACTION: Not adopted by House.

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POSTGRADUATE EDUCATION

Resolution No. 58.
Author: Cedric C. Johnson.
Representing: Sonoma County Medical Society.

WHEREAS, the quality of medical care and services is dependent upon continued effective postgraduate training; and

WHEREAS, the present California Medical Association's Postgraduate Medical and Surgical Assemblies have greatly served in the dissemination of medical advances through regional and circuit courses; there is still a hiatus between "learning about" and "learning to practice expeditiously" these many advances; and

WHEREAS, the principle of "in-service training" developed in business and industry may be applied to provide integrated medical, surgical and special professional training in improved methods, both diagnostic and therapeutic technical procedures; and

WHEREAS, federal and state legislatures and other governmental agencies are tending to encroach upon trends in medical education and practice; and

WHEREAS, there is need for training of greater number of well qualified medical ancillary personnel, clinical laboratory, x-ray technologists, various diagnostic, therapeutic and rehabilitative personnel to meet the increasing demands in private practice, hospitals, clinical pathology, x-ray units and ancillary medical organizations; and

WHEREAS, the scope of the overall development of postgraduate education necessitates combined and integrated consultation knowledge, experience, prestige and financial resources of the medical professional organization, educators, financial consultants and participating individual physicians; now, therefore, be it

Resolved: That the House of Delegates directs the Committee on Postgraduate Activities of the California Medical Association to investigate the feasibility, the ways and means to further the establishment of an integrated school of postgraduate medical education together with provisions for training of ancillary personnel.

ACTION: Referred to Council.

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HEALTH INSURANCE PLANS

Resolution No. 59.

ACTION: Not adopted by House.

SPECIALTY GROUPS

Resolution No. 60.
Author: James M. Thompson.
Representing: San Francisco Medical Society.

WHEREAS, there are well organized societies which represent both specialty and general practice groups in the economic field for the membership; and

WHEREAS, the members of these organizations are members of C.M.A.; and

WHEREAS, certain of these organizations represent the great majority of practicing specialists and general practitioners in studying the particular needs and problems of such groups and their patients; and

WHEREAS, the C.M.A. Committee on Fees has traditionally sought advice in specific matters from representatives of such organizations; and

WHEREAS, it is desirable that such bodies express their needs to—and work through the Medical Services Commission and its committees; now, therefore, be it

Resolved: That (1) Such organizations now organized and which may be organized in the future be encouraged to bring their problems to the Medical Services Commission of the C.M.A., and its committees, and (2) that C.M.A. recognize and encourage the development of such organized groups for the study of economic aspects of medical care and permit those organizations which clearly represent the majority of such specialty and general practice groups to suggest where needed, advisory representatives to the Committee on Fees of C.M.A. and such other committees where such representatives are needed.

ACTION: Adopted by House with minor amendments in wording recommended by the reference committee.

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OLD AGE MEDICAL CARE

Resolution No. 61.
Author: Edgar Wayburn.
Representing: San Francisco Medical Society.

WHEREAS, the provision of overall medical care for persons over 65 years of age is one of the leading socio-economic problems of our generation; and

WHEREAS, the A.M.A. House of Delegates has recognized this outstanding need but has offered a resolution at the December 1958 Clinical Session which overlooks the costs of hospital care, drug therapy and ancillary medical services and the proportionate cost of services by physicians and even the principle of broad pooling of risks; therefore, be it

Resolved: That the House of Delegates of the C.M.A. instruct the California delegation to convey these opinions to the A.M.A. and request that adequate plans be developed as soon as possible to provide persons over 65 with adequate voluntary health insurance coverage; and be it further

Resolved: That all physicians should continue to do whatever they can to give proper medical care to older persons, regardless of cost.

ACTION: Adopted by House.

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HEALTH INSURANCE

Resolution No. 62.

ACTION: Not adopted by House.

* * *

MEDICAL ASPECTS OF IMMUNIZATION

Resolution No. 63.
Author: Robert L. Stirrett.
Representing: L.A.C.M.A. member.

WHEREAS, certain mass immunization programs are being carried out under sponsorship and direction of schools, lay organizations, etc.; and

WHEREAS, lack of responsibility results in incomplete immunizations and follow up booster programs; and

WHEREAS, permanent records are important for future reference by patients, his personal physician, hospital, dispensary, or clinic, in case of illness, accident or epidemic; now, therefore, be it

Resolved: That this House urges immunization of every individual, regardless of ability to pay, and that records of such immunization be maintained and made available to the individual and/or his personal physician.

ACTION: Adopted by House as shown above, which represents amendment from the original introduction on recommendation of the reference committee.

* * *

SENATE BILL NO. 515

Resolution No. 64.
Author: Lewis T. Bullock.
Representing: Los Angeles County Medical Association.

WHEREAS, there has been introduced in the State Legislature, Senate Bill No. 515 which provides for the creation by each county of a Special Medical Care Revolving Fund for Medical Care Recipients; and

WHEREAS, this bill provides a single system of payment for medical services and allows payment directly to the physicians; now, therefore, be it

Resolved: That the Legislative Committee be requested to propose such amendments to Senate

Bill No. 515 as may be consistent with the policy embodied in the final version of Resolution No. 65.

ACTION: Amnded on recommendation of reference committee and adopted in form shown above.

* * *

WELFARE PAYMENTS

Resolution No. 65.
Author: Paul V. Morton.
Representing: Santa Clara County Medical Society.

WHEREAS, confusion exists regarding the method of payment to physicians for services rendered to recipients of the Public Assistance Program; and

WHEREAS, the physicians of some county societies believe, and have so voted, that they prefer direct recipient payments because they,

1. Better preserve a normal doctor-patient relationship.
2. Make the principle of indemnification more feasible.
3. Completely and fully inform the patient of the amount of money allotted for his medical care.
4. Would direct patient complaints and criticisms regarding amounts of medical allowances to the Welfare Department rather than to the physicians.
5. Place the commodity of medicine on the same basis as other basic needs, such as food, shelter, and clothing, which are customarily paid for on a money payment principle, as opposed to payment in kind; now, therefore, be it

Resolved: That a policy of direct payment to the patient by the Welfare Departments be recommended where feasible and desired, and that in local areas where this is not deemed feasible the matter be decided on a local option basis according to the vote of each constituent medical society.

ACTION: Amended on recommendation of the reference committee and adopted by House as shown above.

* * *

CALIFORNIA PHYSICIANS' SERVICE

Resolution No. 66.

ACTION: Not adopted by House.

* * *

PUBLIC ASSISTANCE

Resolution No. 67.

ACTION: Withdrawn by author.

* * *

VETERANS HOME TOWN MEDICAL CARE PROGRAM

Resolution No. 68.
Author: John Murray.
Representing: San Joaquin County Medical Society.

WHEREAS, more and more veterans are obtaining care from the Veterans Administration; and

WHEREAS, there is a home town medical care program for veterans; and

WHEREAS, many veterans have no knowledge of this home town medical care program; now, therefore, be it

Resolved: That the California Medical Association Public Relations Department make additional effort to inform all veterans of the home town medical care program.

ACTION: Adopted by House.

* * *

HEALTH INSURANCE PLANS

Resolution No. 69.

ACTION: Not adopted by House.

* * *

BASIC MEDICAL SCIENCE COMMITTEE

Resolution No. 70.
Author: Thomas Foster.
Representing: Santa Clara County Medical Society.

WHEREAS, it is the obligation of the medical profession not only to provide the public the best possible care, but also to protect the public from incompetent practitioners of the healing arts; now, therefore, be it

Resolved: That the Council appoint a committee specifically for the purpose of reviewing existing Basic Medical Science laws, and the formulation of an appropriate program of action to be submitted for approval and implementation at the next regular session of the C.M.A.

ACTION: Adopted by House.

* * *

Resolution No. 71—See Resolution No. 38.

* * *

MEDICAL FEES

Resolution No. 72.
Author: John F. Needham.
Representing: San Luis Obispo County Medical Society.

Resolutions No. 73 and No. 77 combined with No. 72 and the following substitute resolution offered by the reference comittee:

WHEREAS, the Relative Value Study is medicine's effort to produce a guide for the realistic consideration of medical economics by those interested in voluntary health insurance; and

WHEREAS, some insurance companies have apparently arbitrarily assigned a dollar factor in order to produce a fee schedule; and

WHEREAS, some insurance companies apparently suggest to the public that fee schedules so produced are actually payment in full for medical services

thereby converting an indemnity contract to a service contract; and

WHEREAS, California physicians are not bound by any fixed fee schedule except as physician members of C.P.S. or other service contracts to which they are a party; now, therefore, be it

Resolved: That—

1. The C.M.A. reaffirm the principle of the usual fee indemnity plan incorporating the principle of prior agreement which has been in effect since 1954; and
2. That C.M.A. reaffirm its policy that it is the responsibility of the local medical societies to review, when indicated, the fees charged by their members; and
3. That these local review committees be available to all interested parties concerned whether they be insurance companies, doctors or patients; and
4. That the information contained in this report and resolution be transmitted to the health insurance industry in California; and
5. That we encourage each component medical society to cooperate in the presentation of indoctrination courses for the claims adjustors of health insurance plans and appropriate personnel in their local areas.

ACTION: Adopted by House as proposed by reference committee.

* * *

Resolution No. 73—See Resolution No. 72.

* * *

INSURANCE REPORTS

Resolution No. 74.
Author: Charles C. Gill.
Representing: Los Angeles County Medical Association.

WHEREAS, many insurance companies and public agencies request reports about patients or have letters of inquiry, which is a necessary service the physician must render them; and

WHEREAS, the senders of such letters of inquiry usually furnish only the number of copies of the report they desire, or often ask for the report on the back of the letter they sent; and

WHEREAS, if the doctor wishes a complete record of the entire correspondence he must then make a copy of any letter or form, in order to have both the questions as well as the answers and this is a tedious item of extra work for the physician's office; now, therefore, be it

Resolved: That the C.M.A. notify all insurance companies and public agencies that it would be a courteous time-saver to enclose an extra copy of any letter, form or other inquiry, to be retained by the doctor if he so desires.

ACTION: Adopted by House.

RECOGNITION OF SERVICE

Resolution No. 75.
Author: P. C. Barrette.
Representing: Santa Clara County Medical Society.

WHEREAS, the value and privilege of membership in the C.M.A. is well known to and frequently spoken of by men in and associated with the medical arts; and

WHEREAS, it is not so frequently remembered that the demands pertaining to membership in the C.M.A. are also great; and

WHEREAS, the delegates here gathered recognize the honors and privileges of membership in C.M.A., and to recognize the extent of each year's effort and the expense in time and lucre of maintaining a proper aspect as a member of the C.M.A.; now, therefore, be it

Resolved: That this House of Delegates declares that it is and will be the policy of the C.M.A. through successor Houses of Delegates to accept as a Senior Member, one who comes before the House having completed forty years of medical practice, of which the immediately preceding twenty-five years have been as a member of the C.M.A. Acceptance as a Senior Member entails the forgiveness of C.M.A. dues thenceforth; and be it further

Resolved: That the C.M.A. Councilors prepare a suitable scroll to be presented to any and every Senior Member created by a House of Delegates under this policy declared.

ACTION: Referred to Constitution Study Committee.

* * *

CONFLICTING INTERESTS

Resolution No. 76.

ACTION: Not adopted by House.

* * *

Resolution No. 77—See Resolution No. 72.

AMENDMENTS TO BY-LAWS

Listed below are the amendments to the By-Laws of the California Medical Association which were approved by a two-thirds vote at the 1959 House of Delegates. In some instances, where technical changes were approved, this list shows both the resolution introduced for the amendment and the resulting language from such amendment.

BY-LAW AMENDMENT NO. 1

By-Law Amendment No. 1.
Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter VII, Section 10, of the By-Laws be amended by deleting the words "The secretary shall be chairman of the committee."

The section will now read:

Section 10.—Committee on Scientific Work

There shall be an independent standing committee on scientific work consisting of the secretary, secretaries of the sections on general surgery and internal medicine, and three other members appointed by the Council, each of these three members to serve for terms of three years, one member being appointed each year.

This committee shall determine the character and scope of the scientific proceedings of the Association for each session, and shall invite the guest speakers, subject to the instructions of the Council.

At least thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers and discussions shall be presented.

This committee shall also act as the Committee on Arrangements for the annual session. It shall have charge of all local arrangements not otherwise provided for. It shall provide suitable meeting places and shall have general charge of all local arrangements. It shall have power to appoint local advisory members and subcommittees to aid in its work.

This committee shall have at least one joint session with the section secretaries, at a time and place to be designated by the chairman of the committee, at least forty-five days prior to the annual session. to coordinate more efficiently the various activities of the Association at its annual session. The chairman of the local committee on arrangements shall be invited to attend this meeting.

* * *

BY-LAW AMENDMENT NO. 2

By-Law Amendment No. 2.
Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter V, Section 2, of the By-Laws be amended by deleting the word "November" used in that section and substituting therefor the word "September."

The section will now read:

Section 2.—Representation

Commencing with the 1952 regular session of the House of Delegates, each component society shall be entitled to one delegate for each fifty (50) active members or major fraction thereof, according to its membership as of the first day of September of the preceding year; provided, however, that each component society shall be entitled to a minimum of two delegates.

* * *

BY-LAW AMENDMENT NO. 3

By-Law Amendment No. 3.
Author: Donald D. Lum.
Representing: The Council.

Resolved: That paragraphs (a) through (g) of Chapter VII, Section 1 of the By-Laws be amended by deleting all language therein; and be it further

Resolved: That the following be substituted so this section reads as follows:

Section 1.—Commissions and Standing Committees

This Association has the following commissions and standing committees that are subordinate to the respective commissions as follows:

(a) Commission on Medical Services, responsible for the activities of and through which the following standing committees shall report:

1. Committee on Fees,
2. Committee on Indigent and Aged,
3. Committee on Government Financed Medical Care,
4. Committee on Rehabilitation.

(b) Commission on Public Agencies, responsible for the activities of and through which the following standing committees shall report:

1. Committee on State Medical Services,
2. Committee on Mental Health,
3. Committee on Other Professions,
4. Committee on Veterans' Affairs,
5. Committee on Adoptions.

(c) Commission on Community Health Services, responsible for the activities of and through which the following standing committees shall report:

1. Committee on Rural Health,
2. Committee on School Health,
3. Committee on Industrial Health,
4. Committee on Civil Defense and Disaster,
5. Committee on Blood Banks,
6. Committee on Allied Health Agencies.

(d) Commission on Public Policy, responsible for the activities of and through which the following standing committees shall report:

1. Committee on Legislation,
2. Committee on Public Relations.

(e) Commission on Medical Education, responsible for the activities of and through which the following standing committees shall report:

1. Committee on Postgraduate Activities,

2. Committee on Maternal and Child Care,
3. Committee on Scientific Work.

(f) Cancer Commission, responsible for the activities of this Association in the fields of cancer research, prevention, education and control.

(g) Commission on Professional Welfare, responsible for the activities of and through which the following standing committees shall report:

1. Committee on Health and Accident Insurance,
2. Medical Review and Advisory Board,
3. Committee on Private Practice of Medicine by Medical School Faculty Members.

(h) Judicial Commission, which shall hear and decide all appeals of disciplinary actions taken by component societies in the manner and as provided in Chapter III of the By-Laws.

* * *

BY-LAW AMENDMENT NO. 5

By-Law Amendment No. 5.
Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter V, Section 10, of the By-Laws be amended by deleting the word "November" used in that section and substituting therefor the word "September."

The section will now read:

Section 10.—Duties of Credentials Committee

The secretary of the Association shall supply the Committee on Credentials with the necessary information concerning the membership of the House of Delegates.

The secretary shall give this committee a list of component societies, showing the total membership as of September 1 of the preceding year. This committee shall ask each delegate and alternate to present his written credentials, but shall accept the official written list submitted by the secretary of any component society; provided that such written list be sent to the secretary of the Association at least fifteen days before the beginning of the annual session.

The committee shall make a written report to the House of Delegates of the delegates and alternates entitled to membership therein.

* * *

BY-LAW AMENDMENT NO. 6

By-Law Amendment No. 6.
Author: Donald D. Lum.
Representing: The Council.

Resolved: That paragraphs (c) and (d), Section 3, Chapter VII be amended so that this paragraph shall read as follows:

(c) In nominating commission members, the Council shall endeavor to maintain on the membership of each commission the chairmen of the committees that are subordinate to and report through such commission. Where a commissioner's appointment is by virtue of a committee chairmanship, his term of office on a commission shall correspond to his term as chairman of a subordinate committee. The members of the Commission on Public Policy shall be selected from the members of the Committee on Legislation and the members of the Committee on Public Relations.

(d) The Council may, by three-fourths vote of all voting members, rescind an appointment to a Commission for nonparticipation in commission activities, violations of the code of medical ethics or of any section of the Business and Professions Code pertaining to licensure, privilege or moral turpitude. Vacancies occurring between annual sessions shall be filled by the Council.

(New language in this section represents the second sentence of subsection (c) and the first sentence of subsection (d), together with minor changes in wording for grammatical purposes.)

* * *

BY-LAW AMENDMENT NO. 7

By-Law Amendment No. 7.
Author: Donald D. Lum.
Representing: The Council.

Resolved: That paragraph (b), Section 5, Chapter VII be amended so that this paragraph shall read as follows:

(b) The Council may, by three-fourths vote of all voting members, rescind or withdraw an appointment to a committee for nonparticipation in committee activities, violations of the code of medical ethics or any section of the Business and Professions Code pertaining to licensure, privilege or moral turpitude. Vacancies occurring between annual sessions shall be filled by the Council.

(The amendment represents the addition to the language of the section of the first sentence shown above.)

* * *

BY-LAW AMENDMENT NO. 8

By-Law Amendment No. 8.
Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter VII, Section 9, of the By-Laws is hereby amended to reletter paragraphs (c), (d), and (e) so they will be lettered, respectively, paragraphs (d), (e) and (f); and be it further

Resolved: That new paragraphs (b) and (c) shall be inserted to read as follows:

(b) The Commission on Public Agencies shall study, investigate and from time to time submit recommendations concerning the activities of public agencies or related organizations in the field of medical care and public health matters. It shall allocate to the various standing committees for which it is responsible particular projects within their respective fields.

(c) The Commission on Community Health Services shall study, investigate and from time to time submit recommendations concerning community health services and activities or organizations and/or agencies in related fields of medical care. It shall allocate to the various standing committees for which it is responsible, particular projects within their respective fields.

and be it further

Resolved: That Chapter VII, Section 10 of the By-Laws be deleted as a section and its content as modified herewith be made subsection (1) of Chapter VII, Section 9 (e) of the By-Laws; this modification to be effected so that the first paragraph of that section shall read:

(e) (1) Committee on Scientific Work

The Committee on Scientific Work shall consist of the secretaries of the sections on General Surgery and Internal Medicine, and three other members appointed by the Council, each of these three members to serve for terms of three years, one member being appointed each year.

The remaining paragraphs to remain unchanged; and be it further

Resolved: That Chapter VII of the By-Laws be amended to renumber Sections 11 and 12 so they will be numbered, respectively, Sections 10 and 11.

(These changes define the duties of two commissions, make technical changes in numbering of sections and delete the requirement that the secretary be the chairman of the Committee on Scientific Work.)

* * *

BY-LAW AMENDMENT NO. 9

By-Law Amendment No. 9.
Author: Clyde L. Boice.
Representing: Santa Clara County.

Resolved: That Section 9 of Chapter VI of the By-Laws of the California Medical Association be amended to eliminate the words "while absent from their places of residence."

This section will now read:

Section 9.—Expenses of Councilors and Officers

Councilors and officers shall be allowed railroad fare or mileage, plus an allowance for maintenance expense, (a) in attending Association, district or county society meetings; (b) meetings of committees of the Association; (c) authorized councilor or officer visits to county societies; (d) and otherwise when on official business, authorized or approved by the Council.

* * *

BY-LAW AMENDMENT NO. 10

By-Law Amendment No. 10.
Author: Claude P. Calloway.
Representing: San Francisco Medical Society.

Resolved: That Chapter III, Section 1, paragraph 9, of the By-Laws of this Association, California Medical Association, is hereby amended to read as follows:

(9) *Suspension; Reinstatement of Suspended Member; Probation.*

(a) If the Judicial Council shall determine to suspend an accused member, the term of such suspension shall be within its discretion. A suspended member shall have no rights or privileges in the society. The Judicial Council at the end of the suspended member's period of suspension shall consider the quality of his behavior during his suspension, and shall determine whether he shall be reinstated to membership in good standing or the period of suspension shall be extended. A suspended member shall not be reinstated until he pays all dues accrued during the period of suspension.

(b) If the Judicial Council shall determine to expel an accused member it may, in its discretion, defer the effective date of the order of expulsion during a fixed period of probation. The Judicial Council shall have authority to determine the conditions of probation and the period thereof, including the privileges of membership during probation. If the accused member violates any of the conditions of probation the Judicial Council may terminate probation and the order of expulsion shall thereupon immediately become effective. If the term of probation is fulfilled without violation of any of the probation conditions, the order of expulsion may be set aside by the Judicial Council on application of the accused member. Members on probation shall pay dues.

AMENDMENTS TO CONSTITUTION

The 1959 House of Delegates considered several proposed amendments to the Constitution which, under the terms of the Constitution, must lie on the table for one year before being brought for vote. The amendments to the Constitution acted upon by the 1959 House of Delegates were introduced at the 1958 session and, in accordance with requirements of the Constitution, were published in the official

journal at least twice during the intervening year. A two-thirds affirmative vote was required for passage of each proposed amendment. The following were adopted:

CONSTITUTIONAL AMENDMENT NO. 1
SECRETARY (-TREASURER)

Constitutional Amendment No. 1.
Author: Donald D. Lum.
Representing: The Council.

Resolved: That Article VI, Section 1, of the Constitution be amended by deleting the term "-Treasurer" from the present term "Secretary-Treasurer" so that the named officer shall be known as "Secretary."

The section will now read:

ARTICLE VI.—OFFICERS
Section 1.—Officers

The officers of this Association shall be a President, a President-Elect, a Secretary, a Speaker of the House of Delegates, a Vice-Speaker of the House of Delegates and an Editor.

* * *

CONSTITUTIONAL AMENDMENT NO. 3
REPRESENTATION ON THE COUNCIL

Constitutional Amendment No. 3.
Author: Sam J. McClendon.
Representing: Constitution Study Committee.

Resolved: That Article III, Part B, Section 9, of the Constitution be amended in subparagraph (a) by deleting the words shown in parentheses below and adding the words shown below in italics, so that subparagraph (a) shall read as follows:

(a) Each councilor district, as specified in this Constitution, shall be entitled to one councilor for each 1,000 *active* members, *or major fraction thereof,* according to its membership as of the first day of (November) *September* of the preceding year; provided that each councilor district shall be entitled to a minimum of one councilor.

This section will now read:

Part B.—Council
Section 9.—Composition*

The Council shall consist of:

(a) Each councilor district, as specified in this Constitution, shall be entitled to one councilor for each 1,000 active members, or major fraction thereof, according to its membership as of the first day of September of the preceding year; provided that each councilor district shall be entitled to a minimum of one councilor.

(b) The president, president-elect, speaker and vice-speaker.

In addition, the secretary and editor, ex officio, without the right to vote.

(c) District councilors shall be elected from the councilor districts.

(d) Elected councilors from any one district shall not, at any time, exceed forty per cent (40 per cent) of the total Council membership.

* * *

CONSTITUTIONAL AMENDMENT NO. 5
CONSIDERATION OF CONSTITUTIONAL AMENDMENTS

Constitutional Amendment No. 5.
Author: W. S. Lawrence.
Representing: Butte-Glenn Medical Society.

WHEREAS, any amendment to the Constitution should be for the greatest good of the Association; and

WHEREAS, the most recent amendment to the Constitution which eliminates the councilors-at-large was passed without prior hearings in the appropriate reference committee during any regular session of the Association; and

WHEREAS, this action has denied interested delegates the opportunity to meet, exchange views, discuss the ramifications and evaluate the appropriateness of the amendment to meet its purpose; and

WHEREAS, the proponents of the amendment would be the last to feel the necessity to press such an action through the House of Delegates without adequate consideration; now, therefore, without prejudice to the previous amendment, be it

Resolved: That Article VIII, Section 3, Paragraph 2 of the Constitution be amended by addition of the following:

This section will now read:

Section 3.—Amendments

Any member of the House of Delegates at any meeting of any session, other than a special session, thereof may present an amendment or amendments to any article or articles or any section or sections of any article or articles of this Constitution.

Such proposed amendment or amendments shall be in writing and shall be filed with the secretary and shall thereafter be published at least twice in separate issues of the official journal of this Association prior to the next session of the House of Delegates.

At the said next session, other than a special session, of the House of Delegates, such proposed amendment or amendments shall be submitted to the House of Delegates, for consideration at any meeting of the House of Delegates during that session, and if two-thirds of the delegates present and voting vote in favor thereof, the same shall be adopted.

Further, such proposed amendment or amendments shall be referred to the appropriate reference committee which shall hold hearings on the proposed amendment or amendments during the course of its regular business while the Association is in convention. If the proposal or proposals are introduced during the first session of the House, hearings shall be held at both the current and the next regular meeting. If the proposal or proposals are introduced during the second session, hearings shall be held at the next meeting, and in either event, prior to submission to the House of Delegates for vote.

CONSTITUTIONAL AMENDMENT OFFERED

A proposed amendment to the Constitution of the California Medical Association was offered at the 1959 session and, in accordance with provisions of the Constitution, was referred to the Reference Committee on Amendments to the Constitution and By-Laws. The proposed amendment must lie on the table for one year and be published twice during that period in CALIFORNIA MEDICINE.

The reference committee suggested that this proposal be studied by the Constitution Study Committee during the year. The proposal will be referred in 1960 to a reference committee for additional study and recommendations to the 1960 House of Delegates.

Constitutional Amendment No. 1.
Author: Arthur Olson.
Representing: Santa Barbara County Medical Society.

Resolved: That Article VIII of the Constitution of the C.M.A. be amended by renumbering the present sections in said Article to 2, 3 and 4 and inserting a new Section 1 as follows:

Section 1.—Eligibility for Appointment

Eligibility for appointment or election to any position, to any committee, or to in any way represent the C.M.A., or to formulate policy for C.M.A., shall depend on the member's not holding a salaried position with or acting in an advisory capacity for, or being retained by a commercial insurance company or health plan which handles health or accident problems during the term of election or appointment. Nor shall such delegates or committee members hold a remunerative political position either appointive or elective. Association with California Physicians' Service is specifically excluded.

Council Meeting Minutes

Tentative Draft: Minutes of the 447th Meeting of the Council, Los Angeles, Ambassador Hotel, March 14, 1959.

The meeting was called to order by Chairman Lum in the Regency Room of the Ambassador Hotel, Los Angeles, on Saturday, March 14, 1959, at 9:30 a.m.

Roll Call:

Present were President Reynolds, President-Elect Foster and Councilors MacLaggan, Wheeler, Todd, Quinn, O'Neill, Kirchner, O'Connor, Shaw, Gifford, Harrington, Davis, Campbell, Sherman, Lum, Bostick and Teall. Absent for cause, Secretary Daniels and Editor Wilbur.

A quorum present and acting.

Present by invitation during all or a part of the meeting were Messrs. Hunton, Thomas, Clancy, Marvin, Whelan, Collins and Mrs. Griffith and Dr. Batchelder of C.M.A. staff; Messrs. Hassard and Huber of legal counsel; county society executives Scheuber of Alameda-Contra Costa, Dermott of Sonoma, Jensen of Fresno, Geisert of Kern, Rosenow and Field of Los Angeles, Bannister of Orange, Donmyer of San Bernardino and Neick of San Francisco; Dr. Marshall Porter of the State Department of Mental Hygiene; Dr. William Gardenier and Mr. Wilson Wahlberg of California Physicians' Service; Doctors Francis E. West, Dan O. Kilroy, J. Lafe Ludwig and others.

1. *Approval of Minutes:*

(a) On motion duly made and seconded, minutes of the 445th Council meeting, held February 21-25, 1959, were approved.

(b) On motion duly made and seconded, minutes of the 446th Council meeting, held February 25, 1959, were approved.

2. *Membership:*

(a) A report of membership as of March 11, 1959, was presented and ordered filed.

(b) On motion duly made and seconded in each instance, four applicants were voted Retired Membership. These were: Alberty, W. M., Logsdon, R. O., San Diego County; Atsatt, Rodney, Santa Barbara County; Proescher, Frederick, Santa Clara County.

(c) On motion duly made and seconded in each instance, seven applicants were voted Associate Membership. These were: Wm. H. Tooley, Alameda-Contra Costa County; Byong Sik Kim, George

A. Skinner, Madera County; Harry March, Placer-Nevada-Sierra Counties; Stanley Wolfe, San Francisco County; Herbert Matthews, Samuel Miller, Santa Clara County.

(d) On motion duly made and seconded, reductions of dues were voted for five members because of illness or postgraduate studies.

3. *Welfare Fund Trustees' Request for Meeting:*

Mr. Hassard discussed the background of a request received from certain union labor welfare fund trustees for further meetings with Association representatives on the subject of medical and surgical indemnities to be paid by their trust funds.

After discussion, tabling and later report by a special committee, it was regularly moved, seconded and voted to adopt the following resolution:

Resolved,

1. The C.M.A. Council favor the determination by each county society of the level of usual fees being charged in its area.

2. The C.M.A. Council recommend that this level of usual fees be expressed as a dollar coefficient to current editions of the C.M.A. relative value study, such coefficient to reflect economic conditions in the area concerned.

3. The Commission on Medical Services be requested to stimulate each county medical society to expedite the determination of this level of usual fees as early as possible. For this purpose the Council recommends that the Commission be augmented by the Committee for Emergency Action on an advisory basis.

On motion duly made and seconded, it was voted that the executive committee of the Commission on Medical Services seek to hold another meeting with the fund trustees making the request.

4. *Bureau of Research and Planning:*

Dr. Francis E. West, chairman, reported on a meeting of the Bureau of Research and Planning and submitted several recommendations on which Council approval was sought.

On motion duly made and seconded, it was voted (1) to empower the Bureau of Research and Planning to secure space for a library, (2) to secure the services of a librarian to compile, digest, file and cross-index reference materials, (3) to name, through the Committee on Committee Nominations, two additional members of the bureau to serve in the stead of two members who cannot serve, and (4) to accept the concept that the bureau is an advisory body and is to advise with the various commissions and committees which will then report to the Council.

5. *Report of the President:*

President Reynolds reported on a meeting he had attended in Pittsburgh, Penn., as a member of the Committee on Medical Care Plans of the Council on Medical Service of the American Medical Association.

6. *Nursing Homes:*

On motion duly made and seconded, it was voted to refer to the Commission on Medical Services the overall study of nursing homes.

7. *California Hospital Association:*

The chairman announced, with sorrow, that Howard Hatfield, president of the California Hospital Association, had died. On motion duly made and seconded, it was voted to send letters of sympathy to Mrs. Hatfield and to the California Hospital Association and to adjourn the present meeting in his memory.

8. *Appointment of Secretary:*

On motion duly made and seconded, it was voted to accept, with regret, the resignation of Dr. Albert C. Daniels as secretary of the Association.

Nominations for secretary were received and on the basis of a written ballot, Dr. Matthew N. Hosmer was elected secretary for the Association year ending with the 1960 Annual Session.

9. *Commission on Public Policy:*

Dr. Dan O. Kilroy, chairman of the Commission on Public Policy, Mr. Ben Read and Mr. Hassard reviewed several bills now before the State Legislature, covering such topics as the right of coroners to retain tissues, cancer control, definition of insanity, right to sue for false and malicious statements against professional licentiates and the public assistance law.

Dr. J. Lafe Ludwig, legislative committee member of both the Association and the A.M.A., reported that the Keogh-Simpson bill, which would provide tax deductions for annual amounts set aside into a retirement fund by self-employed persons, would be on the floor of the House of Representatives on March 16.

Dr. Bostick discussed Assembly Bill No. 13, relating to narcotics. On motion duly made and seconded, it was voted to take no action on this measure.

10. *House of Delegates Resolutions:*

The Council discussed the resolutions referred to it by the 1959 House of Delegates or requiring some action by the Council. The following decisions were reached:

RESOLUTION

No. 7—Referred to Commission on Professional Welfare, through Committee on Insurance.

No. 12—Referred to Commission on Medical Services.

No. 13—Referred to Commission on Medical Services.

No. 14—Referred to Commission on Medical Services.

No. 15—Referred to Commission on Medical Services.

No. 17—Referred to Commission on Public Policy.

No. 19—Referred to Commission on Medical Services.

No. 26—Referred to Commission on Medical Services, liaison committee with Department of Social Welfare.

No. 27—Tabled.

No. 29—relative to exfoliative cytology—Referred to Commission on Community Health Services.

No. 35—Staff to send to county societies and resolution referred to Committee on Other Professions.

No. 37—Referred to Commission on Public Policy.

No. 45—Referred to Bureau of Research and Planning for its information, not action.

No. 46—Referred to Committee on Committee Nominations.

No. 49 and No. 50—Staff to send copies to Blue Cross plans, C.P.S. and Health Insurance Council, with request that coverage for services of assistant surgeon be provided.

No. 53—Referred to Committee on Legislation for consideration and framing of suitable legislation which would be brought back to the Council.

No. 58—Referred to Committee on Postgraduate Study for study and report back to the Council.

No. 63—Referred to Commission on Community Health Services.

No. 65—Referred to Committee on Legislation and Commission on Medical Services.

No. 70—Referred to Commission on Public Policy and to Committee on Committee Nominations.

No. 72—Staff to refer to Blue Cross, Blue Shield and Health Insurance Council.

No. 74—Staff to implement.

11. *Finance Committee:*

Dr. Heron, chairman of the Finance Committee, presented a report on bank balances, status of loans, etc., as of March 11, 1959. Report ordered filed.

Discussion was held on a request for a loan by Physicians' Benevolence Fund, Inc. It was agreed to consider this further at a later meeting.

12. *Commission on Medical Services:*

(a) Councilor Harrington, as chairman of the liaison committee with the State Department of Social Welfare, reported on changes in the regulations governing the prescribing of drugs to welfare patients.

On motion duly made and seconded, it was voted to congratulate Mr. George Wyman, recently resigned as Director of the Department of Social Welfare, on his new post with the federal government.

(b) A request of the State Department of Public Health for review of a new set of instructions for the treatment of rabies was reviewed and, on order duly made and seconded, was referred to the Commission on Public Health for study and report back to the Council.

13. *Governor's Conference on Traffic Safety:*

Dr. Bostick reported that C.M.A. representation on the Governor's Conference on Traffic Safety had been requested. On motion duly made and seconded, it was voted to refer this to the Committee on Industrial Health.

14. *Commission on Medical Education:*

Dr. Rosenow presented the new format of *Medical Dates Bulletin* and reported that a pharmaceutical firm had agreed to subsidize the publication of this bulletin for general mailings to the membership each six months and a restricted mailing to medical schools, hospitals and others every two months.

15. *Staff Report:*

Mr. Hunton requested further information on the proposal that commission and committee reports be recorded on magnetic tape for members of the Council. On motion duly made and seconded, it was voted that such reports not be put on tape but be reproduced and augmented by a summary sheet.

Mr. Hassard advised that the staff had suggested that meetings between staff and county society executives and members of the Conference of Local Health Officers be held annually at the time of the Annual Session. On motion duly made and seconded, it was voted to approve this suggestion.

Mr. Hassard also read to the Council the report adopted by the Medical Executives Conference, covering the composition of the conference and its operating procedures.

16. *State Department of Mental Hygiene:*

Dr. Marshall Porter reported that Dr. Daniel Blain, newly appointed Director of the Department of Mental Hygiene, would plan to attend future Council meetings or to be represented at them. He also reported that the department's budget for the 1959-1960 fiscal year had been increased and that

a large part of the increase would be used for professional education.

17. *California Physicians' Service:*

Dr. Heron presented a progress report on the activities of California Physicians' Service, including the proposed new program for older citizens.

18. *Public Relations:*

A request from the San Francisco Medical Society for support of a television program was reviewed and referred to the staff for consideration and report.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 5:45 p.m.

DONALD D. LUM, M.D., *Chairman*
JOHN HUNTON, *Acting Secretary*

In Memoriam

BOWNS, WILLIAM JAMES, JR. Died in Sacramento, March 26, 1959, aged 44, of heart disease. Graduate of University of Southern California School of Medicine, Los Angeles, 1956. Licensed in California in 1957. Doctor Bowns was a member of the Sacramento Society for Medical Improvement.

✤

BOYCE, LEE. Died in San Diego, March 12, 1959, aged 78. Graduate of Jefferson Medical College of Philadelphia, Pennsylvania, 1903. Licensed in California in 1919. Doctor Boyce was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

BRANDENBURG, KENNETH C. Died in Long Beach, March 10, 1959, aged 59. Graduate of University of Illinois, College of Medicine, Chicago, Illinois, 1926. Licensed in California in 1930. Doctor Brandenburg was a member of the Los Angeles County Medical Association.

✤

CALVERT, EDWARD HARRISON. Died in El Cajon, March 19, 1959, aged 70. Graduate of Ohio State University College of Medicine, Columbus, 1927. Licensed in California in 1936. Doctor Calvert was a member of the San Diego County Medical Society.

✤

CLARK, IRA JOSEPH. Died March 5, 1959, aged 83. Graduate of Denver and Gross College of Medicine, Colorado, 1908. Licensed in California in 1912. Doctor Clark was a retired member of the San Diego County Medical Society and the California Medical Association, and an associate member of the American Medical Association.

✤

EDISON, EARL MAYNARD. Died in Monterey Park, February 20, 1959, aged 49, of heart disease. Graduate of Northwestern University Medical School, Chicago, Illinois, 1937. Licensed in California in 1945. Doctor Edison was a member of the Los Angeles County Medical Association.

✤

EVERINGHAM, SUMNER. Died in Oakland, March 4, 1959, aged 73, of cerebral hemorrhage and myelofibrosis with thrombocytopenia and anemia. Graduate of Columbia University College of Physicians and Surgeons, New York, 1910. Licensed in California in 1919. Doctor Everingham was a member of the Alameda-Contra Costa Medical Association.

GIOVINCO, JOSEPH BIVONA. Died in San Francisco, March 20, 1959, of heart disease. Graduate of George Washington University School of Medicine, Washington, District of Columbia, 1924. Licensed in California in 1925. Doctor Giovinco was a member of the San Francisco Medical Society.

✤

HERZOG, GEORGE K., SR. Died in San Francisco, March 16, 1959, aged 80, of complications from a fall in which his hip was broken. Graduate of Cooper Medical College, San Francisco, 1901. Licensed in California in 1901. Doctor Herzog was a retired member of the San Francisco Medical Society and the California Medical Association, and an associate member of the American Medical Association.

✤

JEANS, HOWARD S. Died in Lynwood, February 25, 1959, aged 41. Graduate of George Washington University School of Medicine, Washington, District of Columbia, 1943. Licensed in California in 1944. Doctor Jeans was a member of the Los Angeles County Medical Association.

✤

LEACH, WILLIAM OTTO. Died in Glendale, March 8, 1959, aged 82. Graduate of Wisconsin College of Physicians and Surgeons, Milwaukee, Wisconsin, 1908. Licensed in California in 1923. Doctor Leach was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

MCCLEAVE, THOMAS CROOKE. Died in Berkeley, March 11, 1959, aged 86, of cerebral thrombosis and arteriosclerotic cardiovascular disease. Graduate of Cooper Medical College, San Francisco, 1896. Licensed in California in 1896. Doctor McCleave was a retired member of the Alameda-Contra Costa Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

MCGUIRE, THOMAS EDWARD. Died March 16, 1959, aged 77. Graduate of Maryland Medical College, Baltimore, 1904. Licensed in California in 1922. Doctor McGuire was a member of the Los Angeles County Medical Association.

✤

NEWSON, HOWARD E. Died in San Anselmo, March 21, 1959, aged 65, of a coronary occlusion. Graduate of University of California School of Medicine, Berkeley-San Francisco, 1926. Licensed in California in 1926. Doctor Newson was a member of the San Francisco Medical Society.

NINTH ANNUAL
REGIONAL POSTGRADUATE INSTITUTE
NORTH COAST COUNTIES

Presented by University of California School of Medicine at Los Angeles, Thomas H. Sternberg, M.D., Assistant Dean for Continuing Education in Medicine and Health Sciences, and California Medical Association Committee on Postgraduate Activities.

Hoberg's Resort, Lake County

June 5 and 6, 1959

PROGRAM

FRIDAY, JUNE 5, 1959

9:00-9:30 a.m.—**Office Anesthesiology**—John B. Dillon, M.D.

9:30-10:00 a.m.—**Emotional Problems in Office Practice**—Frank F. Tallman, M.D.

10:15-10:45 a.m.—**Principles of Minor Surgical Procedures**—Franklin L. Ashley, M.D.

10:45-12:00 noon—**Three Panel Symposia** (you may go to one of your choice):

Panel 1: **Treatment of Psychocutaneous Problems**

Panel 2: **Anesthesia for Children and the Aged**

Panel 3: **Modern Prenatal Care**

2:00-2:30 p.m.—**Toxemia of Pregnancy**—Nicholas Assali, M.D.

2:30-3:00 p.m.—**Functional Uterine Bleeding**—J. G. Moore, M.D.

3:15-3:45 p.m.—**Sinusitis: Its Diagnosis, Complications and Treatment**—Jack H. Seltsam, M.D., D.D.S.

3:45-5:00 p.m.—**Three Panel Symposia** (you may go to one of your choice):

Panel 1: **General Problems in Management of Anesthesia for Head and Neck Surgery**

Panel 2: **Well Baby Live Clinic**

Panel 3: **Demonstrations of Minor Surgical Procedures, Utilizing Pigs**

6:00 p.m.—Cocktail Hour—Compliments of Hoberg's Resort

7:00 p.m.—Institute Banquet—Dancing

SATURDAY, JUNE 6, 1959

9:00-9:45 a.m.—**Ophthalmological Problems in Medical Practice**—Bradley Straatsma, M.D.

9:45-10:45 a.m.—**Otitis Media and Otitis Externa: Review of Recent Developments**—Bruce V. Leamer, M.D.

DESCRIPTION OF PROGRAM: In addition to didactic lectures there will be choices of special concurrent Panel Symposia during each half-day session where physicians will have the opportunity of working in small groups. Babies of various ages will be studied during the Well Baby Clinics. Demonstration of Minor Surgical Procedures (utilizing pigs) will be limited to small groups. Sign-up sheets will be available at the Registration Desk. Every effort will be made, however, to schedule additional sections if needed.

10:30-11:00 a.m.—**New Virus Diseases**—John M. Adams, M.D.

11:00-12:00 noon—**Three Panel Symposia** (you may go to one of your choice):

Panel 1: **Well Baby Live Clinic**

Panel 2: **Skin Tumor Clinic**

Panel 3: **Prerequisites and Hazards of Anesthesia**

2:00-2:30 p.m.—**Clinical Application of Steroids in Medical Practice**—Carl Pearson, M.D.

2:30-3:00 p.m.—**Differential Diagnosis of Arthritis**—Melvin H. Levin, M.D.

3:15-3:45 p.m.—**Use of Antihistamines, Tranquilizers and Antipruritics in Diseases of the Skin**—Paul LeVan, M.D.

3:45-5:00 p.m.—**Three Panel Symposia** (you may go to one of your choice):

Panel 1: **Demonstration of Minor Surgical Procedures, Utilizing Pigs**

Panel 2: **Arthritis and Connective Tissue Disease**

Panel 3: **Hemorrhagic Complications of Pregnancy**

Other Special Events:

1. **Medical Motion Pictures**
2. **Scientific Exhibits**

HOST: Sonoma County Medical Society . . . **REGIONAL CHAIRMAN:** R. L. Zieber, M.D., Montgomery Drive and Sotoyome, Santa Rosa. **Institute Fee:** $25.00. For additional information, contact Postgraduate Activities office, California Medical Association, 2975 Wilshire Boulevard, Los Angeles 5. **All California Medical Association members and their families are cordially invited to attend.**

Annual Meeting

Ambassador Hotel

LOS ANGELES

February 21 to 24, 1960

Papers for Presentation

If you have a paper that you would like to have considered for presentation, it should be submitted *to the appropriate section secretary* (see list on this page) no later than August 21, 1959.

Scientific Exhibits

Space is available for scientific exhibits. If you would like to present an exhibit, please write immediately to the office of the California Medical Association, 450 Sutter Street, San Francisco 8, for application forms. To be given consideration by the Committee on Scientific Work, the forms, completely filled out, must be in the office of the California Medical Association no later than September 1, 1959. (No exhibit shown in 1959, and no individual who had an exhibit at the 1959 session, will be eligible until 1961.)

Medical Motion Pictures

The daytime Film Symposiums which proved so popular during the 1959 sessions will be continued in 1960. Evening film programs will be planned for doctors, their wives, nurses and ancillary personnel.

Authors desiring to show films should send their applications to Paul D. Foster, M.D., California Medical Association, 2975 Wilshire Blvd., Los Angeles 5. All authors are urged to be present at the time of showing as there will be time allotted for discussion and questions from the audience after each film.

Deadline is October 1, 1959.

PLANNING MAKES PERFECT
AN EARLY START HELPS

SECRETARIES OF SCIENTIFIC SECTIONS

ALLERGY . . . . . **Hyman Miller**
201 South Lasky Drive, Beverly Hills

ANESTHESIOLOGY . . . . . **Roger W. Ridley**
5914 Birch Street, Riverside

DERMATOLOGY AND SYPHILOLOGY . **Edward L. Laden**
301 North Prairie Avenue, Inglewood

EAR, NOSE AND THROAT . . . **Heinrich W. Kohlmoos**
426 17th Street, Oakland 12

EYE . . . . . **Earle H. McBain**
1530 Fifth Avenue, San Rafael

GENERAL PRACTICE . . . . . **Floyd K. Anderson**
1233 North Vermont, Los Angeles 29

GENERAL SURGERY . . . . . **Philip R. Westdahl**
490 Post Street, San Francisco 2

INDUSTRIAL MEDICINE AND SURGERY . **Edward J. Zaik**
740 South Olive Street, Los Angeles 14

INTERNAL MEDICINE . . . . **Charles D. Armstrong**
1111 University Drive, Menlo Park

OBSTETRICS AND GYNECOLOGY . **John C. McDermott**
2010 Wilshire Boulevard, Los Angeles 57

ORTHOPEDICS . . . . . **Carl E. Horn**
2901 Capitol Avenue, Sacramento 16

PATHOLOGY AND BACTERIOLOGY . . **Robert L. Dennis**
675 East Santa Clara Street, San Jose 12

PEDIATRICS . . . . . **James L. Dennis**
5105 Dover Street, Oakland 9

PHYSICAL MEDICINE . . . . **Joseph E. Maschmeyer**
1720 Brooklyn Avenue, Los Angeles 33

PSYCHIATRY AND NEUROLOGY . . **Leon J. Whitsell**
909 Hyde Street, San Francisco 9

PUBLIC HEALTH . . . . . **Merle E. Cosand**
316 Mountain View Avenue, San Bernardino

RADIOLOGY . . . . . **Frank C. Binkley**
635 East Union Street, Pasadena 1

UROLOGY . . . . . **Morrell E. Vecki**
450 Sutter Street, San Francisco 8

PUBLIC HEALTH REPORT

MALCOLM H. MERRILL, *M.D., M.P.H.*
Director, California State Department of Public Health

THERE ARE striking differences between the various ethnic groups in California for cancer of certain sites, according to a soon to be published department report, "Cancer in California."

Whether racial or socio-economic factors determine these differences is not known. The Negro rate for cancer of the cervix is appreciably higher than that for the white group. In contrast, the breast cancer mortality among white women is nearly twice that of the Negro women.

The actual number of deaths among Chinese due to cancer of the nasopharynx, stomach and liver is several times greater than would be expected (based on cancer death rates for selected sites in the total population). Among the Japanese, deaths due to stomach cancer far exceed general actuarial expectance. Mexican-born women show a three-fold greater rate of lung cancer deaths than do other women in the state.

The report provides information about the state's population, cancer deaths and illness, the concentration of certain forms of the disease in particular segments of the population, and the extent of survival among those affected by the disease.

* * *

Thirty-nine cases of paralytic poliomyelitis were reported during the period January 1 to April 4, as against 23 cases during the same period last year. Of these 39 cases, 18 were reported from Los Angeles, seven from San Francisco and seven from the 16 Central Valley counties.

The 1959 cases follow the same pattern with regard to age groups as the 235 cases of 1958, with 40 per cent occurring in the under five-year age group and 30 per cent in persons over 20 years. Approximately 70 per cent of the cases occur in unvaccinated persons.

For the nation, 187 cases of paralytic poliomyelitis were reported for the period January 1 to March 28, as against 103 for the same period last year. In 1958 more than 3,000 persons were crippled and almost 200 lost their lives from poliomyelitis in the United States.

* * *

The department has been given a byproduct material license by the Atomic Energy Commission, which permits possession of one millicurie each of barium 140, cesium 137, iodine 131, strontium 90, thallium 204, yttrium 90 and mixed fission products.

These materials will be used in the Sanitation Laboratory for the evaluation of analytical techniques for the recovery of radioactive materials in air, water, food and soil, and for the preparation of radioactivity counting standards.

* * *

Severe smog episodes occurred in California again in 1958, according to a report on air pollution published by the Bureau of Air Sanitation.

The report contrasts the severe smog conditions of last year with the more favorable conditions of 1957 when air pollution seemed to be on the decrease throughout the state. The difference in levels between the two years was attributed chiefly to meteorological conditions.

Pointing out that weather conditions conducive to smog occurred over much of the year, the report said that "the experience in 1958 is a reminder that natural forces play an important role in how frequent and how severe our smog episodes will be and that control programs must become effective enough to offset weather conditions which contribute to air pollution attacks."

* * *

A course for physicians on performance of the nalorphine test was scheduled for May 7 by the Postgraduate Division of the School of Medicine, University of Southern California. Because the course is an experiment in this field, and because it is hoped to actually demonstrate and give practice in the administration of the test, registration was limited to ten physicians.

If enough physicians are interested, additional courses may be scheduled. Physicians interested may communicate with the Postgraduate Division of the School of Medicine.

The course is divided into three two-hour sessions, as follows:

1. The Pharmacology of Addicting Drugs and of Nalorphine—Prof. John Leyden Webb, head of the department of pharmacology.

2. Facts and Theories of Narcotic Addiction and Withdrawal—Clinton H. Thienes, M.D., visiting professor of pharmacology.

3. Indications for, and Techniques, Effects and Dangers of the Nalorphine Test for Narcotic Consumption—Charles Hurley, M.D., assistant physician, Pasadena Emergency Hospital.

WOMAN'S AUXILIARY
TO THE CALIFORNIA MEDICAL ASSOCIATION

DURING the past few years several county auxiliaries have reported that many of their members have felt discouraged because of what they consider a lack of interest and understanding by their county medical societies. Where this attitude exists, it would seem to be in direct contrast to the attitude of the California Medical Association Council toward the Auxiliary.

On May 8, 1959, the Woman's Auxiliary to the California Medical Association was 30 years old.

Following is the When, Where and Why of the formation of the Auxiliary.

In 1928 Mrs. John O. McReynolds of Dallas, Texas, president of the Woman's Auxiliary to the American Medical Association, appeared before the Council of the California Medical Association and urged the formation of a California Auxiliary. Convinced of its value, the Council advocated the formation of an Auxiliary and referred the matter to a reference committee with Dr. O. D. Hamlin of Oakland as Chairman. After many meetings and much work of the committee, consisting of Doctors George H. Kress, Edward M. Pallette and Mr. Hartley Peart, a set of rules was formulated for the organizing and regulating of county auxiliaries. This syllabus was sent out from the central office of the California Medical Association prior to the organization of the State Auxiliary at Coronado on May 7, 1929, at a meeting held under the sponsorship and at the instruction of the Council of the California Medical Association.

On May 8, 1929, Dr. William Duffield of Los Angeles, at the request of the California Medical Association, called together a group of physicians' wives who were present at the convention of the C.M.A. being held in Coronado. To this small group were presented a few of the many problems confronting the medical profession, with an explanation of the efforts being made in some states to solve these problems through the medium of auxiliaries to medical societies. At this time the first state officers were elected: President, Mrs. Henry Rogers, Petaluma; vice-president, Mrs. W. H. Geistweit, San Francisco; second vice-president, Mrs. J. H. Shepard, San Jose; secretary and treasurer, Mrs. Clara Cushman, Santa Ana.

This simple gesture brought into being the Woman's Auxiliary to the California Medical Association.

There were forty-six charter members at this meeting, representing seventeen counties—Alameda, Contra Costa, Fresno, Los Angeles, Marin, Mariposa, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara and Sonoma.

Ten county auxiliaries were organized during the first year—Alameda, Contra Costa, Los Angeles, Monterey, Napa, Orange, San Bernardino, San Diego, Santa Barbara and Sonoma. In April 1930 there was a total membership of 472.

There are 58 counties in the State and 50 of these are organized into 40 county medical societies with a membership today of 16,700, including 561 associate members. In the Woman's Auxiliary we have 42 counties organized into 34 county auxiliaries. Three of these county auxiliaries have branch auxiliaries, Los Angeles five, and Alameda and Santa Clara each one. Five of the unorganized counties are represented by eight members-at-large. These counties are Plumas, Madera, Yolo, Siskiyou and Mariposa. The total membership in the Auxiliary is 6,625, which includes 245 associate members.

Although we have made great progress in our membership in the past 30 years we have less than 50 per cent of our potential. I study our accomplishments of these past years and think of the great possibilities . . . if we had 100 per cent membership. We could achieve this goal with the help of all C.M.A. members.

I am happy to report that the California Medical Association Council further indicated its interest and belief in the need for the Auxiliary when it adopted the following Resolution on October 11, 1958:

WHEREAS, the Heller report recommended a closer liaison with the Woman's Auxiliary to the California Medical Association; and

WHEREAS, the special Council committee on the Heller report endorsed this recommendation and urged that the Auxiliary be made to feel more a part of the Association in its activities; and

WHEREAS, this recommendation was endorsed by the Council; now, therefore, be it

***Resolved:* That this Council urge all county medical societies to encourage the formation of countywide auxiliaries; and be it further**

***Resolved:* That all physician members of the C.M.A. be encouraged to urge their wives' participation in the Auxiliary and its activities; and be it further**

***Resolved:* That the annual reception honoring the President's wife also honor the President of the Woman's Auxiliary to the California Medical Association.**

Our Auxiliary projects and activities are so varied that we offer something of interest for every physician's wife and an opportunity for her to assist organized medicine by serving in her community as an Auxiliary member.

MRS. THEODORE A. POSKA
President, Woman's Auxiliary to the California Medical Association

NEWS & NOTES

NATIONAL • STATE • COUNTY

KERN

Dr. William C. Buss, health officer of Kern County for the past 21 years, resigned that position early last month owing to ill health. Dr. William H. Coe is acting health officer.

LOS ANGELES

Dr. Roger O. Egeberg, medical director of Los Angeles County General Hospital, has been appointed county director of mental health services by the board of supervisors. In this capacity he will coordinate plans for the county's participation in mental health clinics for care of mental patients in their own community under the provisions of the Short-Doyle Act.

* * *

Grants totalling $64,189 to aid studies by six Los Angeles researchers into **various aspects of cancer** were announced recently by the California Division of the American Cancer Society. The grants and the projects were as follows:

To Dr. Irving Gordon of the University of Southern California School of Medicine, $20,635 for investigation of the possible role of virus infection in pulmonary cancer.

To Dr. Hans L. Falk, USC School of Medicine, $20,143 to continue a study of carcinogenic effect of certain chemicals found in polluted air.

To Drs. William Hartman and **William G. Clark** of the University of California School of Medicine at Los Angeles and the Veterans Administration, $13,891 for extension of a $46,000 five-year study of chemical compounds produced in tumors.

To Dr. Max S. Dunn of the UCLA Department of Chemistry, $8,484 for continuation of studies of effects of growth inhibitors on tumors.

To Dr. Ralph McKee of UCLA School of Medicine, $1,036 to supplement a previously awarded grant of $40,000 for a five-year investigation of the nature and action of large molecules in cancer cells.

* * *

The University of Southern California School of Medicine will offer another **Postgraduate Refresher Course in Hawaii** and on board the S. S. Lurline from July 29 through August 15, 1959, Dr. Phil R. Manning, director of the school's postgraduate division, announced recently.

In addition to the lectures, the announcement said, there will be workshops in electrocardiogram and x-ray interpretation as well as problems of water and electrolyte balance and the differential diagnosis of jaundice. During most hours, several programs run simultaneously so that the participating physician may choose the topics most suited to his needs.

Further information about the course may be obtained by writing to the Director of the Postgraduate Division, USC School of Medicine, 2025 Zonal Avenue, Los Angeles 33.

A donation of $800,000 for the construction in Santa Monica of a center for **study and treatment of both mentally retarded and emotionally disturbed children** has been made by the Joseph P. Kennedy, Jr., Memorial Foundation. The center is to have facilities for observation and treatment of some 900 patients a year. Dr. George M. Tarjan, superintendent of the Pacific State Hospital at Spadra, is collaborating on plans for the physical plant and its operation, it was announced.

The Kennedy Foundation was established by Joseph P. Kennedy, Sr., former United States ambassador to England, in memory of his son, who was killed during World War II.

* * *

Receipt of a gift of $93,000 from the Commonwealth Fund, New York, to be used for the furnishings of the basic sciences teaching building being built at its medical center by the University of Southern California was announced recently by Dr. Clayton G. Loosli, dean of the school.

SACRAMENTO

Dr. John G. Walsh of Sacramento was chosen president-elect of the American Academy of General Practice at the organization's convention in San Francisco in April. He will succeed to the presidency at the meeting next year. Last year Dr. Walsh, who is a member of the editorial board of CALIFORNIA MEDICINE, served as chairman of the American Academy's board of directors. He is a past president of the California Academy of General Practice.

SANTA BARBARA

Dr. James T. Case of Santa Barbara, who was for many years professor of radiology at Northwestern University School of Medicine, was presented with the Janeway Medal of the American Radium Society at the organization's 41st annual meeting, held at Hot Springs, Va., last month. Dr. Case delivered the annual Janeway Lecture. The medal, which honors late Dr. H. H. Janeway, pioneer radiation therapist, is presented annually to an outstanding physician or medical scientist.

GENERAL

Recent improvements in the diagnosis and in the treatment of patients with obstruction of the peripheral blood circulation will be highlighted at the annual **scientific sessions of the California Heart Association,** to be held at the Hotel Wilton, Long Beach, May 23. Dr. Henry Barcroft, professor of physiology, St. Thomas Hospital, London, will be a guest panelist at roundtable discussion of blood flow measurement.

The scientific program, scheduled from 9 o'clock in the morning to 4 in the afternoon, will include a review of recent research developments in the surgical treatment of strokes, treatment of pulmonary disorders, fluid balance, and factors influencing blood lipids.

The problem of heart disease and compensability under workman's compensation will be reviewed. Also on the program is a discussion on the relationship between trauma or strain and heart disease.

POSTGRADUATE EDUCATION NOTICES

THIS BULLETIN of the dates of postgraduate education programs and the meetings of various medical organizations in California is supplied by the Committee on Postgraduate Activities of the California Medical Association. In order that they may be listed here, please send communications relating to your future medical or surgical programs to: Mrs. Margaret H. Griffith, Director, Postgraduate Activities, California Medical Association, 2975 Wilshire Boulevard, Los Angeles 5.

UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Fetal Electrocardiography. Friday and Saturday, June 5 and 6. Twelve hours. Fee: $40.00.

Workshop for Food Service Workers—Equipment Maintenance. Monday and Tuesday, June 15 and 16. Twelve hours. Fee: $20.00 (includes two lunches).

Office Urology. Wednesday, June 17. Six hours. Fee: $30.00.

Surgical Technique Utilizing the Isolated Intestinal Segment in Urological Procedures. Thursday, June 18. Seven hours. Fee: $150.00.†

Eighth Annual Symposium in Clinical Laboratory Technology. Saturday and Sunday, June 20 and 21. Twelve hours. Fee: $20.00 (includes one lunch).

Dissection of the Thorax, Abdomen and Pelvis. Wednesday and Thursday, June 24 and 25. Fourteen hours. Fee: $80.00.†

Dissection of the Extremities. Friday, June 26. Seven hours. Fee: $40.00.†

Hand Surgery. Saturday and Sunday, June 27 and 28. Twelve hours. Lecture and laboratory, $60.00. Lecture only, $35.00.

Clinical Neurology. Wednesday, July 8 to August 12. Thirty-six hours. Fee: $100.00.

Infertility. Friday and Saturday, July 24 and 25. Twelve hours. Fee: $60.00.

The Impact of Surgery on Anesthesia. Wednesday, Thursday and Friday, August 5, 6 and 7. Eighteen hours. Fee: $60.00.

Common Problems of the Foot. Friday and Saturday, September 11 and 12. Nine hours. Fee: $35.00.

Three Summer Seminars at University of California Residential Conference Center, Lake Arrowhead (all fees at Lake Arrowhead include room and board):

Pediatric Cardiology. Sunday through Wednesday, August 16 through 19. Fifteen hours. Fee: $137.50.† Guest speaker: John Lind, M.D., Stockholm, Sweden.

Emotional Problems in Office Practice. Wednesday through Sunday, August 19 through 23. Fifteen hours. Fee: $150.00.†

Seminars in Internal Medicine. Sunday through Wednesday, August 23 through 26. Fifteen hours. Fee: $137.50.†

Clinical Traineeships—Anesthesia and Dermatology. Dates by arrangement. Minimum period—two weeks. Fee: Two weeks, $150.00; four weeks, $250.00.

Contact: Thomas H. Sternberg, M.D., Assistant Dean for Postgraduate Medical Education, U.C.L.A., Los Angeles 24. BRadshaw 2-8911, Ext. 7114.

† Limited enrollment.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Practical Aspects in the Management and Treatment of Cardiovascular Disease. Saturday, Sunday and Monday, May 16, 17 and 18. Twenty-one hours. Fee: $35.00.

Secondary Glaucoma. Thursday, Friday and Saturday, May 21, 22 and 23. Twenty hours. Fee: $75.00.

Pediatrics. Wednesday through Saturday, June 17 through 20. Twenty-eight hours. Fee: $20.00 per day.

Fundamental Practices of Radioactivity and the Diagnostic and Therapeutic Uses of Radioisotopes. Two or three month course limited to one enrollee per month. Fee: $350.00.

Contact: Seymour M. Farber, M.D., Assistant Dean, Department of Continuing Medical Education, University of California Medical Center, San Francisco 22. MOntrose 4-3600, Ext. 665.

STANFORD UNIVERSITY SCHOOL OF MEDICINE

Morning Clinical Conferences, each Monday, Room 515. *Contact:* D. H. Pischel, M.D., Professor, Division of Ophthalmology, Stanford University School of Medicine, 2398 Sacramento St., San Francisco 15.

Contact: Mrs. Alice Crouch, Postgraduate Secretary, Stanford Medical School, 2398 Sacramento St., San Francisco 15.

UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES

Cardiac Resuscitation. Sponsored by the Los Angeles County Heart Association each Wednesday throughout the year, 4 to 6 p.m. USC Medical Research Building, Room 211, 2025 Zonal Avenue. Residents and interns of Los Angeles County, and all armed forces medical personnel admitted without fee. Tuition for all other physicians $30.00. (Each session all-inclusive.)

Basic Home Course in Electrocardiography. One year postgraduate series, electrocardiogram interpretation by mail. Physicians may register at any time and receive all 52 issues. Fifty-two weeks. Fee: $100.00.

Advance Home Course in Electrocardiography. One year postgraduate series, electrocardiogram interpretation by mail. Fifty-two issues: $85.00. Physicians may register at any time.

SPECIAL ANNOUNCEMENT: Last summer a postgraduate refresher course held in Hawaii was so successful that the USC School of Medicine will offer another refresher course in Hawaii and on board the *S.S. Lurline* from July 29 to August 14. (As a time and money saver, round trip air travel is also possible July 29 to August 10.)

Intensive Review of Internal Medicine. Monday through Friday, September 21 through October 2. 9 to 12:30 a.m.*

Alumni Homecoming Course. Recent Advances in Medicine. Thursday and Friday, November 5 and 6. Fee: $50.00.

Contact: Phil R. Manning, M.D., Associate Dean and Director, Postgraduate Division, University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 33. CApital 5-1511.

* Fees to be announced.

COLLEGE OF MEDICAL EVANGELISTS

Each Six Months. Anesthesiology (6 months, full-time). Vacancy occurs each six months. Limited to 2 students. Tuition: $350.00.

For information contact: G. E. Norwood, M.D., assistant dean and chairman, Division of Postgraduate Medicine, College of Medical Evangelists, 1720 Brooklyn Ave., Los Angeles 33. ANgelus 9-7241, Ext. 214.

CALIFORNIA MEDICAL ASSOCIATION POSTGRADUATE COURSES

POSTGRADUATE INSTITUTES

NORTH COAST COUNTIES in cooperation with UCLA School of Medicine, June 5 and 6, Hoberg's Ranch, Lake County. Chairman: Lee Zieber, M.D., 1177 Montgomery Dr., Santa Rosa.

SACRAMENTO VALLEY COUNTIES in cooperation with University of Southern California School of Medicine, June 25 and 26, Tahoe Tavern, Lake Tahoe. Chairman: Robert H. Quillinan, M.D., 616 Alhambra Blvd., Sacramento.

* * *

AUDIO-DIGEST FOUNDATION, a nonprofit subsidiary of the C.M.A., offers (on a subscription basis) a series of six different hour-long tape recordings covering general practice, surgery, internal medicine, obstetrics and gynecology, pediatrics and anesthesiology. Designed to keep physicians posted on what is new and important in their respective fields, these programs survey current national and international literature of interest and contain selected highlights of on-the-spot recordings of national scientific meetings, panel discussions, symposia, and individual lectures. For information contact Mr. Claron L. Oakley, Editor, 1919 Wilshire Blvd., Los Angeles 57, HUbbard 3-3451.

Medical Dates Bulletin

MAY MEETINGS

AMERICAN UROLOGICAL ASSOCIATION, Western Section, 35th Annual Convention, May 17 through 21, Monterey Fairgrounds. *Contact:* James Ownby, Jr., M.D., 516 Sutter Street, San Francisco, or Monterey Peninsula Convention Bureau, Box 489, Monterey.

LOS ANGELES SOCIETY OF NEUROLOGY AND PSYCHIATRY meeting, Wednesday, May 20, 1959, 8:00 p.m., Los Angeles County Medical Association Auditorium. Program: "Impressions of Soviet Science" by Dr. H. W. Magoun. *Contact:* Robert P. Sedgwick, M.D., secretary-treasurer, 2010 Wilshire Blvd., Los Angeles 57.

THE NEVADA ACADEMY OF GENERAL PRACTICE Annual Meeting, May 21 through 23, Riverside Hotel, Reno. Program by University of Southern California School of Medicine. *Contact:* Roy M. Peters, M.D., chairman, 475 S. Arlington Avenue, Reno, Nevada.

CALIFORNIA HEART ASSOCIATION Annual Meeting, May 22 through May 24, 1959. Scientific Session and Directors Meeting, Lafayette Hotel, Long Beach. *Contact:* J. Keith Thwaites, executive director, 1428 Bush Street, San Francisco 9.

SUMMER AND FALL MEETINGS

WESTERN BRANCH, AMERICAN PUBLIC HEALTH ASSOCIATION Annual Meeting. June 2 through 5, Sheraton-Palace Hotel, San Francisco. *Contact:* Mrs. L. Amy Darter, secretary-treasurer, 2151 Berkeley Way, Berkeley 4.

NEVADA STATE MEDICAL ASSOCIATION, Annual Session, jointly with Reno Surgical Society, August 19 through 22, Mapes Hotel, Reno. *Contact:* Nelson B. Neff, executive secretary, P. O. Box 188, Reno.

SAINT JOHN'S HOSPITAL Postgraduate Assembly, September 10 through 12, Saint John's Hospital, Santa Monica. *Contact:* John C. Eagan, M.D., director, Postgraduate Assembly, 1328 22nd Street, Santa Monica.

WASHINGTON STATE MEDICAL ASSOCIATION Annual Meeting, September 13 through 16, Olympic Hotel, Seattle, Washington. *Contact:* Ralph W. Neill, executive secretary, 1309 Seventh Avenue, Seattle, Washington.

OREGON STATE MEDICAL SOCIETY Annual Meeting, September 23 through 25, Medford, Oregon. *Contact:* Mr. Roscoe K. Miller, executive secretary, 1115 S.W. Taylor St., Portland 5, Oregon.

SAN FRANCISCO HEART ASSOCIATION 29th Annual Postgraduate Symposium on Heart Disease. September 30, October 1 and 2, 9 a.m. to 5 p.m. daily, St. Francis Hotel, San Francisco. *Contact:* Lawrence I. Kramer, Jr., executive director, 259 Geary Street, San Francisco 2. YUkon 2-5753.

WESTERN INDUSTRIAL MEDICAL ASSOCIATION, INC. 18th Annual Meeting, held in conjunction with Third Western Industrial Health Conference, all day October 2 and 3, Statler Hotel, Los Angeles. *Contact:* A. C. Remington, M.D., medical director, AiResearch Mfg. Co., 9851 Sepulveda Blvd., Los Angeles 45.

CALIFORNIA SOCIETY OF INTERNAL MEDICINE Annual Meeting, October 2 through 4, Miramar Hotel, Santa Barbara. *Contact:* Mrs. Mildred B. Coleman, executive secretary, or Clyde C. Greene, Jr., M.D., secretary-treasurer, 350 Post Street, San Francisco 8.

CALIFORNIA LEAGUE FOR NURSING Annual Meeting, October 8 through October 10, U. S. Grant Hotel, San Diego. *Contact:* Ruth I. Jorgensen, general director, Room 202, 465 Post St., San Francisco 2.

CALIFORNIA ACADEMY OF GENERAL PRACTICE 11th Annual Scientific Assembly, October 11 through 14, 9:00 a.m. to 5:00 p.m., Hotel Statler, Los Angeles. *Contact:* William W. Rogers, executive secretary, 461 Market Street, San Francisco.

AMERICAN ACADEMY FOR CEREBRAL PALSY Annual Meeting, November 30 through December 2, Statler Hotel, Los Angeles. *Contact:* Margaret H. Jones, M.D., local arrangements chairman, associate professor of pediatrics, UCLA School of Medicine, Los Angeles 24.

1960 MEETINGS

RESEARCH STUDY CLUB of Los Angeles Midwinter Clinical Conference, third week of January, Ambassador Hotel, Los Angeles. *Contact:* Norman Jesberg, M.D., secretary, 500 S. Lucas Avenue, Los Angeles 17.

CALIFORNIA MEDICAL ASSOCIATION Annual Meeting, February 21 through 24, Ambassador Hotel, Los Angeles. *Contact:* John Hunton, executive secretary, 450 Sutter Street, San Francisco 8; or Ed Clancy, director of Public Relations, 2975 Wilshire Blvd., Los Angeles 5.

SOUTHWESTERN PEDIATRIC SOCIETY Spring Lecture Series, March 1 and 2, Statler Hotel, Los Angeles. *Contact:* Wendell Severy, M.D., program chairman, 11633 San Vicente Blvd., Los Angeles 49.

INFORMATION

What Is the California Medical Assistants' Association?

DOCTORS, are you satisfied with your office medical assistant?

Is she taking advantage of all opportunities to improve her knowledge and education, the better to serve the medical profession and the public?

Is she a good public relations representative for the medical profession?

Does she belong to a medical assistants' organization?

Are you aware that such an organization exists?

There is such an organization. In California it is endorsed by the California Medical Association, and its name is California Medical Assistants' Association of California. It began in 1952 when medical assistants in Northern California joined to form the California Medical Assistants Society. In 1953 a similar group was started in the southern part of the state, and soon afterward correspondence between the two groups began. Representatives from both sections attended a meeting in Kansas City in 1955 to organize a national association. The two California groups merged in 1956 and the new statewide organization was incorporated on March 17, 1957. Since then many new component chapters have come into the state organization; at present 35 county organizations with a total of over 1,900 members are represented.

The organization has the full support and approval of the California Medical Association and the American Medical Association. Patterned after medical societies, it is composed of county chapters which make up the state organization, which in turn is a component of a national association.

The American Association of Medical Assistants was endorsed by the American Medical Association at its 1956 meeting in Seattle. At present there are 20 affiliated state units and over 6,500 members. California led in number of members in 1958 with 1,892. There are ten physician advisors, one appointed by the A.M.A. from its Board of Trustees. Dr. Steward H. Smith of San Diego is the advisor from California.

The first annual convention, following two organizational meetings in the Midwest, was held in San Francisco in October, 1957. At the 1958 convention held in Chicago, registration totaled 472. The A.M.A. sponsored a tour of its headquarters and a program for those who attended. The association now has an office at 510 Dearborn Street in Chicago, just across the street from A.M.A. headquarters. An executive secretary is to be employed this year. The 1959 convention will be held October 16-18 in Philadelphia.

Information to acquaint physicians with the assistants' association was provided in a brochure, "WHO, WHAT, WHEN, WHERE, WHY of the California Medical Assistants' Association," that was distributed at an annual meeting of the California Medical Association. Excerpts from it follow:

WHO . . .

We are the women who assist the doctors of California. We are the nurses, receptionists, secretaries, bookkeepers and technicians. We handle the business and technical details of the doctors' offices, thereby leaving the physician free to practice medicine; to serve his patients with the skill, care and judgment which he has acquired. The Medical Assistants' respect for the Profession makes them strive for better public relations; to be ethical in all dealings with patients and in their participation in the civic affairs of the community.

WHAT . . .

In their efforts to elevate the standards of procedure in doctors' offices and clinics they have joined forces with other county organizations to form a State Association. *It is not, and shall never become, a trade union or collective bargaining agency.* Its purpose is a sincere and cooperative interchange of knowledge and ideas on how to improve public relations in medical endeavors.

WHEN . . .

The C.M.A.A. began to take effect in 1952, and after a merger of north and south groups, it became incorporated on March 17, 1957.

WHERE . . .

Each member is a member of her own local county organization which is endorsed by its own county medical society. The California Medical Association approves of a statewide organization and provides an advisory committee as do the local county societies.

WHY . . .

The purposes of this association are:

To bring members into a closer relationship, thereby promoting mutual understanding and a spirit of cooperation between the members;

To promote the interests of the members and to secure better public relations;

To provide a means whereby all Medical Secretaries and Assistants may become associated together and work toward the common good of the medical profession;

To enlarge the opportunities of the members through education, scientific and business training, and the participation in vocational activities;

In general, to promote the highest standards of endeavor among Medical Assistants.

Already educational programs have been set up by C.M.A.A. In 1958 a series of five educational symposia were held at various widely separated places in the state so that all members would have an opportunity to attend at least one. These were held on Sundays (a medical assistant's only sure day off) in the months of September and October, in the following cities: Chico, Burbank, Berkeley, San Diego, and Bakersfield. They were very well received. A total of about 800 medical assistants attended. A registration fee of one dollar for each session was charged. Meetings were held in hospital auditoriums, colleges or hotels, members paying for their own luncheons. Doctors and other speakers gave unselfishly of their time to instruct the medical assistants. The symposia will be repeated in 1959, and all medical assistants, whether members or not, are urged to attend. Details will be forthcoming.

Most local chapters have educational programs at their monthly meetings. Physician speakers are most popular; medical films are shown; and office procedures are explained. Other programs feature public health, Community Chest organizations, rehabilitation, telephone etiquette, good grooming, and occasional dinner meetings. In addition to educational speakers at regular meetings, most chapters have weekly educational workshops or medical lectures. In many of the large cities medical assistant courses are sponsored by adult education boards of the public school systems. Some state colleges and junior colleges have regular courses suitable for medical assistants, a few being taught by C.M.A.A. members.

Each chapter has one or more philanthropic projects. One chapter supplied the furnishings for a hospital room at a cost of about $1,500. Others send underprivileged children to summer camps or sponsor needy families, and some are offering scholarships for future medical secretaries and student nurses. Methods of fund raising vary from rummage sales to fashion shows and dinners.

On several political issues of mutual interest, the Assistants' Association has recorded its support or its opposition along with that of organized medicine. A legislative committee, with a chairman in Sacramento, works with the Public Health League of California and keeps members of C.M.A.A. informed of proposed legislation of interest to the medical profession.

In another area of influence, when urged to do so by the California Medical Association, members of the Assistants' Association called their employers' attention to the importance of filling out and returning the Relative Value Study questionnaire.

New officers of the C.M.A.A., who took office at the annual convention in Pasadena, April 18, are: President, Mrs. Anne Reece, Porterville; president-elect, Mrs. Lauretta Cole, Santa Barbara; first vice-president, Mrs. Helen Anderson, Encinitas; second vice-president, Mrs. Helen McDonald, Oakland; treasurer, Mrs. Maryanne Neill, San Francisco; recording secretary, Miss Nina Rudolph, San Francisco, and corresponding secretary, Miss Emmy Kibler, Tulare County.

The Advisory Board for Internal Affairs is composed of three physicians and two C.M.A.A. members: Steward H. Smith, M.D., San Diego; Vincent M. Dungan, M.D., Visalia; Leon O. Desimone, M.D., Los Angeles; Mrs. Mary Kinn, Orange County, and Mrs. Elisabeth Massey, San Diego.

April has been designated the month for a C.M.A.A. membership drive. Many county medical societies are dedicating their April bulletins to medical assistants, and each medical assistant society is dedicating its own bulletin and planning special programs for prospective members. Doctors are invited to attend local and state meetings to learn more about the organization, and above all are urged to send their medical assistants. For any additional information you may contact Mrs. Kathryn Allen, membership chairman, 14407 Califa, Van Nuys, or, any of the above listed officers.

As to what the California Medical Assistants' Association has to offer its members:

1. Membership in local, state, and national organizations. Association with people in their own field. Regular monthly meetings and social gatherings within the local organization. Annual state and national conventions.

2. Information. Most local chapters have bulletins published monthly. State and national bulletins are published quarterly.

3. Education on local, state and national levels, at little or no expense to members.

4. Insurance. Through the national organization a most comprehensive hospital, surgical, and salary replacement insurance program is offered, which cannot be equalled elsewhere.

5. A better future in the member's own field through the knowledge gained through association and educational programs. Eventual certification of medical assistants is planned.

M.D. QUOTES ABOUT MEDICAL ASSISTANTS

"The American Medical Association has faith in you and it will continue to assist you in developing good educational programs and in winning wider

acceptance among the medical profession. . . . The American Medical Association is your ally in our efforts to improve health and fight disease. There never was a more worthwhile campaign. Best wishes to you."—DR. F. J. L. BLASINGAME, *Vice-President and General Manager*, American Medical Association.

"The American Association of Medical Assistants is doing a job that would do justice to an organization ten times its size."—DR. MORRIS FISHBEIN.

"The American Association of Medical Assistants has accomplished much, but there is a long road ahead—with a brilliant future. You have won the confidence of the American Physician. . . . Because of A.A.M.A., what has been a common occupation is developing into an uncommon profession."—DR. FRED STERNAGEL, *A.A.M.A. Advisor*, Iowa.

"Your many outstanding contributions to the progress of medical treatment and research merit the gratitude of all Californians."—GOODWIN J. KNIGHT, *former Governor of California*, in a telegram to A.A.M.A., Annual Convention, San Francisco, 1957.

"Your code of ethics and obligation in acceptance of membership in your organization indicate that your purposes are of the highest caliber. . . . I should say, personally, that that doctor is fortunate, indeed, who has an assistant who is earnestly following your written aims."—DR. HERMAN A. IVERSON, *Past President*, Humboldt-Del Norte County Medical Society.

"Your jobs are the most important position in the entire private practice of medicine. Few of us doctors keep in mind the importance of our medical assistants who have to keep our offices running smoothly and pleasantly until something happens to keep them from the office—that is a real disaster." —From "The Perfect Medical Assistant," DR. JAMES B. GRAESER, C.M.A.A. Symposium, Hotel Claremont, Berkeley, September 28, 1958.

"The doctors in Santa Clara County should consider themselves fortunate that there is here an active chapter of the American Association of Medical Assistants. Theirs is a society dedicated *not* to ways and means of getting more pay or to improving their working conditions, but to ways of improving themselves so that they can do a better job for [physicians]. They are learning better public and patient relations, more efficient ways of getting their jobs done, and ways to help [physicians] better serve their patients. We should give all the encouragement we can, not only for our aides to join this Society of Medical Assistants but to attend meetings. This encouragement should not only be in the form of persuasion or suggestions, but also financial. Pay her initiation fee, pay her yearly dues, and also for her meals that go along with their monthly meetings. The two, three, or even four dollars a month will not mean nearly as much to you as it does to her; and, besides, inasmuch as it is for the betterment of our offices, it should be considered an office expense."—DR. LELAND B. BLANCHARD, San Jose, California.

New Mental Hygiene Director

DR. DANIEL BLAIN, nationally known psychiatrist and administrator in the field of mental health, on March 1 took the reins as director of California's Department of Mental Hygiene following announcement of his appointment as head of the state's largest agency by Governor Edmund G. Brown.

For ten years medical director of the American Psychiatric Association, Dr. Blain left that post last year to become professor of clinical psychiatry at the University of Pennsylvania in Philadelphia, and to serve as director of mental health training and research for the Western Interstate Commission for Higher Education (WICHE). He remained active with APA as director of its program for recruitment, distribution and utilization of psychiatrists. He also serves as a consultant to the Veterans Administration. At the time of his appointment, Dr. Blain had just completed a four-month tour of 14 western states to examine their programs for WICHE in line with efforts of its Council on Mental Health Training and Research to establish interstate cooperative programs for use of training and research facilities.

Much the same type of cooperative use of California's facilities, involving public and private agencies and use of all community resources, was outlined by Dr. Blain on taking office as State Director of Mental Hygiene. He said his plans would rely heavily on prevention, research, and methods of obtaining and training more personnel in the psychiatric field.

Dr. Blain's rich background as a mental health administrator includes organization of psychiatric services in the Merchant Marine during World War II, and spearheading of the movement for reforms in veterans' psychiatric care as postwar chief of psychiatry for the Veterans Administration. He has also written numerous articles for professional publications. His choice as director, Governor Brown stated, was unanimous among an informal Governor's Advisory Committee made up of Dr. Frank Tallman, former mental hygiene director; Dr. Karl Bowman, professor emeritus of psychiatry at the University of California Medical School and former head of Langley Porter Neuropsychiatric Institute; and Superior Judge W. B. Neeley of Los Angeles.

Dr. Blain was born in China, the son of missionary parents. He graduated from Washington and Lee, then took his medical degree at Vanderbilt University. Married, he is father of a son who is also now a student at Washington and Lee. Dr. Blain's medical affiliations include certification in psychiatry by the American Board of Psychiatry and Neurology, fellowship in the American Psychiatric Association and the American College of Physicians, and membership in the American Medical Association, American Psychoanalytic Association, American Psychopathological Association, Inc., Association for Research in Nervous and Mental Disease, American Sociological Society, plus numerous consultative affiliations.

Medical Examinations—When Required by Law

THE 1957 California legislative session resulted in enactment of Senate Bill 1093 which substantially altered and broadened the discovery procedures in civil litigation. This legislation was modeled primarily upon the discovery rules in effect in the Federal Courts and became effective on January 1, 1958.

These discovery procedures are so new that their full impact has not, as yet, been fully realized by the public and the members of the bar. In some respects, the legislation will affect in one fashion or another the practice of medicine. This article will deal only with a restricted portion of this legislation related to the provisions for physical and mental examinations of people in civil litigation. The pertinent sections of the California Code of Civil Procedure are section 2032, which generally provides for the authority to require submission of a party to physical, mental or blood examination, and section 2034, which provides certain sanctions for failure to comply with an order of court.

Section 2032, in part, provides that, in an action in which the mental or physical condition or the blood relationship of a party is in controversy, the court may order the party to submit to a physical or mental or blood examination by a physician. The order may be made only for good cause shown and shall specify the time, place, manner, conditions and scope of the examination and the person or persons by whom it is to be made. If requested, the party causing the examination to be made shall deliver to the person examined or party to the action a copy of a detailed written report of the examining physician, setting out his findings and conclusions, and if a physician fails or refuses to make such a report, the court may exclude his testimony if offered at the trial. In this connection, it should be noted that in *Jorgensen* v. *Superior Court*, 163 ACA 589, the District Court of Appeal of the State of California held that there is no attorney-client privilege which would cloak the report and justify a refusal upon demand to deliver a copy to the other party in the action, or the person examined.

The court further stated that if such reports *were* privileged, that privilege would be waived by virtue of procuring the physician's examination upon which the report is based.

Section 2034 of the California Code of Civil Procedure, in part, provides that, if any party refuses to obey such an order, the court may make an order that the physical or mental or blood condition of the person sought to be examined shall be taken to be established for the purposes of the action in accordance with the claim of the party seeking the examination and an order refusing to allow the disobedient party from introducing evidence of the physical or mental or blood condition of the person sought to be examined. Although the code provides penalties for disobedience of the order, the usual contempt proceedings will also apply.

Prior to the adoption of the code sections, there was no express statute permitting or compelling a physical examination of a party by a physician. However, the courts, in several cases, held that a trial court could compel such examinations under other sections of the Code of Civil Procedure. As a practical matter, the parties often stipulated that such an examination be performed and this custom is still followed by attorneys.

The statute contains several safeguards for the litigants. It requires the party seeking the order for examination to make a motion with proper notice to all other parties and to the person to be examined. This assures a full and open hearing by the court which permits all individuals to present their arguments.

The notice of motion, a formal legal document giving the parties notice of the hearing, must specify the time, place, manner, conditions and scope of the examination and the person or persons by whom it is to be made. Any disagreements on these points can be stated at the hearing before the court.

The court, in the exercise of its power to order the examination would have due regard for the feelings of the person to be examined and the proprieties of the case, to the extent that the ends of justice will permit in any particular legal action.

The physician or surgeon chosen by the litigants or appointed by the court and undertaking to conduct the examination should follow closely the order of the court specifying the place, manner, condition and scope of the examination. (It should be noted, however, that in the majority of cases such examinations will be conducted pursuant to the stipulation

of the parties without the necessity for a court order.)

A physician performing such examinations should also keep in mind the necessity for detailed written reports setting forth his findings and conclusions. The code specifically provides that failure or refusal to make such a report will be sufficient grounds for excluding his testimony at the time of trial. Such a result might destroy the physician's usefulness to the persons requesting the examination.

The examinations performed by a physician are of extreme importance to all of the parties involved in the litigation. It behooves the physician, acting as such in the capacity as examiner for one or the other of the parties, to follow scrupulously the order of the court providing for the examinations and/or the instructions of the attorney requesting said examinations to insure that the examinations accomplish the purpose desired in assisting the court to arrive at a fair determination of the litigation.

For Your Patients—

Health Insurance is GOOD *Medicine*

Historically, the California Medical Association, of which I am a member, was one of the nation's pioneers in the field of medical care insurance through its sponsorship of the California Physicians' Service. Blue Shield-CPS is a "service plan" as the name implies. It provides medical care rather than a specified sum of money which, in case of illness, you would collect from an insurance company's "indemnity plan."

The folder enclosed explains in considerable detail the various types of coverage. I think the information will be valuable to you and your family.

California Physicians' Service and insurance company programs guarantee your continued freedom of choice of doctor and hospital. It means that if you have this type of protection, our fine relationship, that of patient and personal physician, will not be interrupted as it would be if you became a "captive patient" in a panel practice type plan.

Sincerely,

_____, M.D.

MESSAGE NO. 5. Attractive, postcard-size leaflets, you to fill in signature. Available in any quantity, at no charge as another service to CMA members. Please order by Message Number from CMA, PR Department, 450 Sutter, San Francisco. (Message No. 5 is to be accompanied by CMA's folder "Health Insurance is **Good** Medicine." Folders will be included in your order.)

THE PHYSICIAN'S *Bookshelf*

THE BIRTH OF NORMAL BABIES—Lyon P. Strean, M.Sc., Ph.D., D.D.S., F.A.P.H.A.; Consultant, Norristown State Hospital, Norristown, Pa.; Consultant, Montgomery Hospital, Norristown, Pa. Twayne Publishers, Inc., 31 Union Square West, New York 3, New York, 1958. 194 pages, $3.95.

The theme of this book is to the effect that abnormalities in fetal development are due almost exclusively to the occurrence of some stressful situation during the first three months of pregnancy. Abortions and stillbirths are attributed to the effects of a variety of infections and metabolic and emotional disorders. The mechanism suggested in most instances is the excessive production of cortisone by the adrenal gland in response to the particular stress at a time in pregnancy when various organs and structures are still in a formative stage. Also held responsible for some abortions and abnormalities, especially of the central nervous system, are hypoxia and avitaminosis (especially vitamin B_6). The abnormalities referred to include cleft palate, hare lip, club feet, syndactylism, spina bifida, imbecility, mongolism, congenital heart defects, congenital cataract, etc. The stresses range from trauma, to physiologic events, to a wide variety of emotional upsets.

The author bases his thesis upon the results of animal experimentation in the production of fetal death or abnormality as reported in the literature and as carried out by himself, and upon a series of case histories. A few of the case histories will reveal the flavor of the dissertation: Kick in stomach—malformed right arm, attempted abortion—mongolian idiot, knee injury—cleft palate, tooth extraction—imbecile, poison ivy dermatitis—malformation of gut, hyperemesis—cleft palate, gonorrhea—stillbirth.

The reasoning is *post hoc, propter hoc* I am afraid. Many of the statements made are naive from a medical viewpoint and the whole affair is oversimplified. Heredity is recognized as an occasional cause of abnormality only.

Based on the author's belief he has developed the "Ten Commandments of Genesis" which seek to outline the principles to be followed in order to insure the birth of better babies—such as avoid traumatic stress, avoid physiologic stress (and if you get German measles at two months of pregnancy be sure to take gamma globulin), take multivitamin capsules daily, avoid emotional stress, avoid high altitude flying, avoid drugs such as morphine, tranquilizing agents and cortisone, etc.

This is a very interesting little book in spite of what I believe is gross overstatement and oversimplification. No doubt too many abnormalities have been attributed to "defective germ plasm" and to defective genes in the past and as such regarded as more or less inevitable. The suggestion that greater care and attention in the first three months of pregnancy might assist in avoiding abnormalities or abortion is good and points up the great importance of this formative stage of fetal development.

DANIEL G. MORTON, M.D.

MYASTHENIA GRAVIS—Kermit E. Osserman, M.D., F.A.C.P.; Physician-in-Charge, Myasthenia Gravis Clinic, The Mount Sinai Hospital, New York; Assistant Attending Physician, The Mount Sinai Hospital. Grune & Stratton, New York, 1958. 286 pages, $10.00.

This little book, written by a recognized authority, has much to offer anyone interested in myasthenia gravis, either as the disease presents itself clinically or as it stands in relation to current researches on neuromuscular physiology. Dr. Osserman has provided a book which should be required reading for internists, pediatricians, neurologists, or surgeons who are called upon to manage this uncommon but fascinating disease.

The section on pathology, especially in relation to thymic and cardiac changes, and the illustrations of the muscle cellular pathology will be instructive to those who have felt that the disorder was simply a chemical imbalance at the neuromuscular junction.

In the chapter on physiology one finds, in summary form, a comprehensive review of the modern concepts of neuromuscular transmission. Especially valuable is the clear discussion of the various types of chemical and electrical defects which can produce muscle weakness or paralysis. The reader who has sufficient time and curiosity to read even a few of the many papers referred to in the section on pathophysiology will find a seemingly inexhaustible field of somewhat conflicting data, and the clarity with which Dr. Osserman has dovetailed the experimental results with the clinical problem deserves praise.

The sections on clinical aspects and treatment, complications, and surgical management are without equal as far as this reviewer is concerned, and if the physician does not have the time to struggle with the pharmacology and electrical properties of muscle, he may omit the first few chapters and still deal with the disease effectively. Nowhere will the reader find more attention to the details of clinical management or better instructions in the handling of complications. The values and dangers of the drug tests are thoroughly covered in the section on diagnosis, but the reader may come away with the impression that a diagnosis of myasthenia gravis is not as simple as some of the standard texts would suggest. Nothing could be closer to the truth, and Dr. Osserman has made every attempt to help the clinician evaluate all types of muscle weakness.

Thoracic surgeons will find compelling arguments for or against thymectomy, depending on the individual situation. Pediatricians may find much of interest in the chapters dealing with myasthenia in infants and children.

The book is recommended to anyone who has tried, or is likely to have to try, to diagnose and treat myasthenia. The chances are that anyone who is interested enough to consider seriously the diagnosis of myasthenia in a weak patient will find the answer here, but it is only fair to warn that the extensive bibliography may present a temptation incompatible with busy practice.

TEXAS SURGEON—Donald T. Atkinson, M.D. Ives Washburn, Inc., New York. $3.50.

TO WORK IN THE VINEYARD OF SURGERY: THE REMINISCENCES OF J. COLLINS WARREN (1842-1927)—Edited by Edward D. Churchill, M.D. Harvard University Press, Cambridge, Mass. $6.00.

In these readable and thought-provoking books can be seen, through the lives of two surgeons, some of the diversity of approach and much of the idealism in action that have long characterized the practice of medicine in the United States. The career of Donald T. Atkinson, M.D., included work as a small boy deep in the mines of Canada and immigration to New England. After removal to the Dakotas and attendance at medical school in Kentucky there followed a series of triumphs over frontier conditions in the Southwest. Such a lifetime is strictly in the American tradition. Quite different was the career of Professor J. Collins Warren, M.D. Son of a distinguished medical scholar, Dr. Warren developed his talents in the urban New England tradition and served long and well as a member of the Harvard University medical faculty. Physicians who read these books will certainly recognize some of their own attitudes and hopes in the pages of these interesting memoirs.

From the time of the American Revolution the Warren name has meant something in the history of medical scholarship. Through the skillful editing of Dr. Edward D. Churchill, the meaning of such a brilliant family contribution to medical students, physicians, and the public is made abundantly clear. The editor's notes are in themselves important contributions to medical history. Indeed, the 36-page essay on the evolution of medical teaching at Harvard is a masterpiece of readability and synthesis. Without Dr. Churchill's labors we would not have this assembled reminiscence of Dr. Warren with its insights on pioneering in surgery in America and Europe from the Civil War to the turn of the century. There is a chapter on the kind of life led by a young physician during the Civil War that will certainly arouse the interest of all who enjoy reliving, vicariously, the course of that monumental conflict. But it is the chapters on the gradual development of surgical techniques in Europe, Great Britain, and this country in the 19th century that are the real contribution of the book. Dr. Warren's citation for an honorary degree in 1906 read: "John Collins Warren, Instructor and Professor of Surgery in Harvard University for thirty-five years; author, and eminent practitioner in surgery; the enthusiastic, winning, and indefatigable promoter of the great undertaking of the Medical School, who knew how to inspire others with his own well-grounded hopefulness and ardor."

The wisdom of Dr. Atkinson in *Texas Surgeon* speaks through his fine prose: "In my lifetime I have seen almost unbelievable advances in the healing art. . . . As for knowledge of the body's make-up and its workings, it has grown so swiftly in step with the new insights and measurements of physics and chemistry that I cannot keep up with it all. . . . None of this material had even been clearly anticipated when I was a boy. In this sense I feel myself lucky indeed to have covered such a mighty span of medical development in my lifetime. From the times of Grant, when I was born, to the present of Eisenhower, the river of knowledge has grown enormously. And to have been borne along by this great current has been an adventure far more exhilarating than my youth's wildest imaginings."

Thinking of the problem of financing medical care costs at the present day, this Texas pioneer who once treated Judge Roy Bean and his son, Sam, "at either hip a Colt .45," writes penetratingly, "Either people must on their own initiative learn to save systematically against periods of illness and at the same time spontaneously see to it that doctors are trained to serve them, or an active minority will someday contrive to revolutionize the whole setting. Very naturally I would prefer the first alternative to prevail, and the second I would deplore. But that the first will prevail absolutely, from my observations of human nature, is rather too much to expect. A compromise, then, is my hope."

These are books by surgeons and of special interest to surgeons. Yet this layman reviewer profited from them and recommends them to all who are interested in the role of medical practice in American society. As for medical students, they cannot help but get some thrill of anticipation as they hear Dr. Atkinson, a veteran of 2,500 eye operations in one hospital alone, say simply, ". . . I restored sight to hundreds. In this accomplishment I take satisfaction, a sentiment in which altruism and its spiritual rewards unquestionably figure. Yet there is more to it than hugging myself for having done good, rather than ill, to others. Equally important is the surgeon's gratification in having to some extent correctly sensed and worked within nature's subtle lawfulness. Which is by way of saying that a man must also live for himself, if he is to be successful in living for others." These are worthwhile books.

VAUGHN D. BORNET, PH.D.

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GENERAL OPHTHALMOLOGY — Daniel Vaughan, M.D., Assistant Clinical Professor of Ophthalmology, University of California School of Medicine, San Francisco; Robert Cook, M.D., Clinical Instructor, Department of Ophthalmology, University of California School of Medicine, San Francisco; and Taylor Asbury, M.D., Assistant Professor of Ophthalmology, College of Medicine, University of Cincinnati, Cincinnati, Ohio. Lange Medical Publications, Los Altos, California, 1958. 328 pages, $4.50.

This book with its modest binding and its simple title is one of the most readable, concise, and informative books I have had the privilege to read.

This book is a compend of the knowledge of the teaching staff in the department of Ophthalmology at the University of California.

The authors have done an excellent job in producing a book which every student and every clinician should have readily available. The pathology, the diagnostic points and the accepted treatment are beautifully outlined. The illustrations are adequate.

This is a book that should have wide acceptance.

ALFRED R. ROBBINS, M.D.

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CLINICAL EPIDEMIOLOGY — John R. Paul, M.D., Sc.D., Professor of Preventive Medicine, Yale University School of Medicine. The University of Chicago Press, 5750 Ellis Avenue, Chicago 37, Illinois, 1958. 291 pages, $5.00.

Dr. Paul, as shown by his interesting and important writings, has been concerned for many years with the epidemiological side of various diseases, notably rheumatic fever, poliomyelitis, hepatitis and others. One of his principal theses has been emphasis on the ecological side of disease from the broad standpoint. One welcomes this book, therefore, as a systematic exposition of these ideas. First come chapters on the principles of what Dr. Paul chooses to call "clinical epidemiology" followed by discussions of their application to the study of certain sample diseases. While a good deal of what is said is already familiar ground to physicians, as for example the points raised in the discussion of coronary occlusion, nevertheless Dr. Paul's position is well taken and a deliberate and conscious exposition of the subject is timely and worthwhile. An immense amount of valuable material is presented in 300 pages which can be studied to advantage by every student of medicine and of biology.

ARTHUR L. BLOOMFIELD, M.D.

NUTRITION AND ATHEROSCLEROSIS — Louis N. Katz, M.D., Director, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital; and Professorial Lecturer in Physiology, University of Chicago; Chicago, Illinois; Jeremiah Stamler, M.D., Previously Assistant Director, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago, Illinois and Established Investigator of the American Heart Association; Presently Director, Heart Disease Control Program, Chicago Board of Health, Chicago, Illinois; and Ruth Pick, M.D., Assistant Director, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago, Illinois and Established Investigator of the American Heart Association. Lea & Febiger, Philadelphia, 1958. 146 pages, 67 illustrations, $5.00.

Dr. Katz, who is well known for his long-time research on certain aspects of nutrition and atherosclerosis, now summarizes in a brief monograph a vast amount of factual material on the question with a bibliography of some 800 references. There are 67 tables and charts. The author distinguishes the "built-in" hazards of developing arteriosclerosis such as hereditary factors, hypertension and others, but emphasizes especially the external factors, such as diet, which he believes serve to promote arteriosclerosis in those predisposed. All the statements made are heavily documented.

ARTHUR L. BLOOMFIELD, M.D.

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RELIGIOUS DOCTRINE AND MEDICAL PRACTICE —Richard Thomas Barton, M.B., B.S., M.D., F.A.C.S., Charles C. Thomas, Publisher, Springfield, Illinois, 1958. 94 pages, $3.75.

This small book is designed to provide a reference for questions of religions dogma as they pertain to the practice of medicine. This is a complicated business because of the very considerable differences in the beliefs of various faiths and, indeed, in the sects found within many great religions, and between the teachings of the founder and the actual practice. Consequently, a volume which attempts to cover such a wide range accurately has difficulty with documentation.

The author emphasizes that his book is in no way complete. The reviewer finds both the historical and the religious portions somewhat superficial. The completeness and the exactness are at their best in the section on Catholicism, next in other Christian religions and at their worst in the discussions of religions of Asiatic and of Middle Eastern origin. Which is perhaps as it should be, considering the people at whom the book is aimed.

All in all, this is a handy, small concise reference, perhaps the best available to the local profession.

EDGAR WAYBURN, M.D.

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PENICILLIN—Antibiotics Monographs, No. 9—Harold L. Hirsh, M.D., and Lawrence E. Putnam, M.D., Washington, D.C. Foreword by Harry F. Dowling, M.D. Medical Encyclopedia, Inc. 30 East 60th Street, New York 22, N. Y., 1958. 148 pages, $4.00.

The reason for this book on penicillin is succinctly and comprehensively stated in the foreword by Dr. Dowling: "For 15 years, doctors have been treating patients with penicillin. Many physicians in practice today do not know what illness can be like without penicillin. . . . During these 15 years several highly effective antibiotics have been introduced, but penicillin still remains supreme in several respects. . . ."

The comprehensive approach ends largely with the foreword and the book rapidly becomes a combination of a miniature textbook of medicine of no particular distinction and a "cookbook"-type compilation of penicillin prescriptions. It is both tiresome and wasteful to have recurring paragraphs every few pages . . . "50,000 units every four hours, 100,000 units every six hours, 200,000 units every eight hours, or 500,000 units every 12 hours. . . ." Most of this is an insult to the reader's intelligence, a waste of paper, and an indication of an archaic approach to the presentation of sensible chemotherapy. To make it somewhat worse all this cookbook material is presented twice, in the text and in separate tables.

There is also a peculiar lack of discrimination in the material presented. One wonders, for example, what might be the purpose of listing all penicillin preparations, from crystalline penicillin G through a penicillin-streptomycin-bacitracin dental paste, without any comment concerning the applicability of the preparation, or a judgment on its worth. Likewise the authors quote a number of reports from the literature without any attempt at interpretation.

From the above it is evident that this reviewer has little admiration for this book and believes that it is a very undistinguished member of this series of monographs. Few physicians will want to purchase the monograph and I doubt that drug companies will distribute it gratis.

ERNEST JAWETZ, M.D.

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STREPTOMYCIN AND DIHYDROSTREPTOMYCIN—Antibiotics Monographs, No. 10—Louis Weinstein, Ph.D., M.D., Professor of Medicine, Tufts University School of Medicine; Lecturer on Infectious Disease, Harvard Medical School; Chief of the Infectious Disease Service and Senior Physician, Medical Service, New England Center Hospital, Boston, Massachusetts; and N. Joel Ehrenkranz, M.D., Assistant Professor of Medicine, University of Miami School of Medicine; Chief of the Infectious Diseases Section, Jackson Memorial Hospital, Miami, Florida. Foreword by Chester S. Keefer, M.D. Medical Encyclopedia, Inc., 30 East 60th Street, New York 22, N. Y., 1958. 116 pages, $4.00.

After the preceding monograph, this No. 10 is like a delightful breath of fresh air. The straightforward, unassuming yet sophisticated presentation is in keeping with the authors' high competence as investigators and clinicians. Tabular material and figures from the literature or the authors' own experience are used to illustrate specific, important points.

The chemical, biological and pharmacological properties of streptomycin and dihydrostreptomycin are presented with discrimination and the use of the drugs in general medicine is superbly described. Tuberculosis is specially omitted, because it forms the basis for another monograph in the series. Of particular value and importance are the thoughtful sections on superinfection, intrathecal administration in influenzal meningitis, and the general risks and advantages of that route, in various forms of meningitis. Four hundred and sixty references are thoughtfully interpreted.

This is an excellent little book which must grace the library of every hospital.

ERNEST JAWETZ, M.D.

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MANUAL FOR THE APHASIA PATIENT — Mary Coates Longerich, Ph.D., College of Medical Evangelists, School of Medicine, Los Angeles, California. Foreword by J. M. Nielsen, M.D. The Macmillan Company, New York, 1958. 277 pages, $4.75.

This is a practical guide for the speech therapist dealing with patients with aphasia, giving specific directions for treatment, with suggestions of the place of the family in the total treatment picture. Although it is conceivable that with the aid of this manual treatment might be undertaken by members of the family without the help of a speech therapist, this would probably be only in exceptional cases.

HENRY NEWMAN, M.D.

SURFACE AND RADIOLOGICAL ANATOMY (For Students and General Practitioners), Fourth Edition—W. J. Hamilton, M.D., D.Sc., F.R.S.E., Professor of Anatomy in the University of London at Charing Cross Hospital Medical College, sometime Regius Professor of Anatomy in the University of Glasgow, formerly Professor of Anatomy in the University of London at the Medical College of St. Bartholomew's Hospital; and G. Simon, M.D., B.Ch., D.M.R.E. (Cantab.), F.F.R., Demonstrator of Radiological Anatomy in the Medical College of St. Bartholomew's Hospital, and Radiologist to the Diagnostic X-ray Department, St. Bartholomew's Hospital, and to the Brompton Hospital, London. The Williams & Wilkins Company, Baltimore 2, Maryland, 1958. 355 pages, $9.50.

This new edition has extensive revision and rearrangement of text, with new illustrations and roentgenographic reproductions, to improve the coverage of surface and radiological anatomy.

Following a chapter on general anatomy and methods, anatomical areas are discussed, in general, as follows: Surface contours, surface and skeletal landmarks, superficial muscles and tendons, joint movements and roentgenology. The special organs and regions are covered separately and well illustrated, with some 416 figures. An appendix contains tables of ossification, and a table of segmental innervation of muscles of the extremities.

While the subtitle of the book states that it is for students and general practitioners, many others will find it of interest.

The authors of the present edition are, respectively, an anatomist and a radiologist attached to two medical colleges in London, England.

L. HENRY GARLAND, M.B.

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TUMORS AND TUMOROUS CONDITIONS OF THE BONES AND JOINTS—Henry L. Jaffe, M.D., Director of Laboratories and Pathologist, Hospital for Joint Diseases, New York, N. Y.; Consultant, Armed Forces Institute of Pathology, Washington, D. C. Lea & Febiger, Philadelphia 6, Pa., 1958. 629 pages, 701 illustrations on 194 figures, $18.50.

This monograph presents an integrated account of tumors of bones and joints. The clinical, radiological and pathological findings pertaining to the various lesions are discussed, frequently illustrated and correlated. The author makes a welcome attempt to consider the radiological findings in terms of gross pathology rather than microscopic; then adding the microscopic findings. There are short sections on treatment.

The various benign and neoplastic conditions taken up in the thirty-three chapters include: Giant cell tumor, bone cyst, aneurysmal bone cyst, benign chondroblastoma, chandromyxoid fibroma, benign and malignant tumors of cartilage, fibrosarcoma, osteogenic sarcoma, and such other conditions as osteoid-osteoma, fibrous dysplasia, pigmented villonodular synovitis, synovioma, chordoma, and also certain cysts and tumors peculiar to the maxillae. Subjects also include juxtacortical chondroma, juxtacortical osteogenic sarcoma, fibrous cortical defect, desmoplastic fibroma, and benign osteoblastoma.

To a large extent, the text conveys the author's personal conceptions of the lesions involved. His great experience warrants considerable attention being paid to many of his suggestions and conclusions.

In the section on giant cell tumor, the author states that post-irradiation sarcoma may develop, but fails to stress the fact that several authors have reported sarcoma developing in what was apparently benign giant cell tumor many years after diagnosis or surgical treatment, and *without* the intervention of radiotherapy. It would seem important to add this point to subsequent editions. The author uses the term "solitary bone cyst" rather than localized fibrous dysplasia; the reasons for this are adumbrated in a paragraph dealing with the differential diagnosis of cyst and solitary focus of fibrous dysplasia. The matter is somewhat academic, but might bear expansion in a subsequent edition.

The author refers to the common finding of vertebral hemangioma at autopsy but believes that many of the benign hemangiomas of bone interpreted in the roentgenograms of the spines of living persons are "mere focal varicosities rather than true hemangiomas." The evidence for this opinion is not given. The experience of your reviewer is that benign hemangiomas of the vertebrae are indeed quite common, just as benign hemangiomas of the cutaneous and subcutaneous tissues are.

The book is handsomely printed and illustrated. It will be welcomed by surgeons, pathologists and radiologists.

L. HENRY GARLAND, M.B.

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CARDIAC ARREST AND RESUSCITATION—Hugh E. Stephenson, Jr., M.D.; Professor and Chairman, Department of Surgery, University of Missouri School of Medicine, Columbia, Missouri; Chief of Surgical Service, University of Missouri Hospitals; Associate-in-Charge, Cardiovascular Program, State Crippled Children's Service, University of Missouri; Consultant, Whiteman Air Force Base Hospital; Markle Scholar, John and Mary R. Markle Foundation, 1954-1959. The C. V. Mosby Company, St. Louis, 1958. 378 pages, $12.00.

This comprehensive and carefully documented volume will serve as an excellent reference book on the subject of cardiac resuscitation. The various aspects of the problem are individually considered and are presented clearly and in detail. The volume of material, however, is excessively large and interferes with the book's attempt to emphasize the important points and fundamentals of the problem. Little effort is made to distinguish between the clearly documented physiologic information on cardiac arrest and the large fund of opinions, many of which are unscientific. No one would quarrel with the cautious and well-supported statements the author makes, but one would hope for a more authoritative approach to a complex subject about which misinformation abounds.

In an extensive historical background, credit is given to nearly every contributor to this field; however, the author does not emphasize the importance of the fundamental concepts outlined by Wiggers and Wegria some 20 years ago.

This book would be more suitable as a general reference volume rather than as a manual for surgeons on the prevention and management of cardiac arrest.

BENSON B. ROE, M.D.

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ORAL SURGERY—Third Edition—Kurth H. Thoma, D.M.D., Professor of Oral Surgery, Emeritus, Harvard University. The C. V. Mosby Company, St. Louis, 1958. 1607 pages, 1824 illustrations, including 159 in color, $27.50.

This is a lengthy, scholarly text on the subject of oral surgery. The book is definitely a reference book in the field and is not the type of book that one would read for ordinary comprehensive information about the field of oral surgery. It is massive, well done, beautifully illustrated and detailed in its discussions of etiology, pathology and clinical appearance of lesions of the oral cavities.

The section on surgical treatment is not too well done and the illustrations on surgical operations about the head and neck are rather meager.

The book is recommended as a reference book in the field of oral surgery, not for cursory perusal or rapid source of comprehensive information in the general field of oral surgery. It is scholarly, well done, but excessively detailed. Libraries and specialists would do well to own this book but the general surgeon, the general practitioner need not have it for his library shelves.

GYNECOLOGIC RADIOGRAPHY—Jean Dalsace, M.D., Chief of Sterility Service, Broca Hospital, University of Paris, Paris; and J. Garcia-Calderon, M.D., Radiologist, University of Paris School of Medicine, Paris; with a chapter on Radiography of the Breast, by Charles M. Gros, M.D., and Robert Sigrist, M.D. Foreword by I. C. Rubin, M.D.; translated by Hans Lehfeldt, M.D. A Hoeber-Harper Book (Paul B. Hoeber, Inc., Med. Book Dept. of Harper & Brothers), 49 East Thirty-third Street, New York 16, N. Y., 1959. 188 pages, $8.00.

In this modest atlas of hysterosalpingography, translated from the French, it is suggested that radiography of the female genital organs should be undertaken much more often than has been our custom in this country. This advice may be difficult to reconcile with the current limitation of radiation involving gonads and early pregnancies. The book contains 305 figures, most of which are excellent reproductions of radiographs, including a few that show breast structures. The major emphasis is on submucous myomas and polyps, cervical and endometrial cancer, and obstruction of Fallopian tubes. The authors believe that skillful hysterography should lead to the diagnosis of cancer in its early stages, but this would seem to be a crude and potentially dangerous device for cancer detection.

As one looks down the long list of items illustrated in this atlas, including even a few normal pregnancies, it becomes obvious that hysterography is useful mainly in establishing the presence of congenital malformations. Even in the diagnosis of tubal occlusion, some workers now prefer culdoscopic visualization of the passage of injected dyes and direct study of peritubal adhesions.

This book is beautifully made and can be recommended as a work of art to radiologists and as an item of at least historical interest to gynecologists. There is a brief foreword by the late Isidor Rubin, who concluded with this apt phrase—"insofar as they have gone, the authors have succeeded admirably."

C. E. McLennan, M.D.

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EMERGENCY SURGERY—Seventh Edition—Hamilton Bailey, F.R.C.S. (Eng.), F.A.C.S., F.R.S.E., Emeritus Surgeon, Royal Northern Hospital, London; Consulting Surgeon, the Italian Hospital; General Surgeon, Metropolitan Ear, Nose, and Throat Hospital; Vice-President of the International College of Surgeons; formerly Hunterian Professor, Royal College of Surgeons of England, and External Examiner in Surgery, University of Bristol. The Williams and Wilkins Company, Baltimore, 1958. 1197 pages, $32.50.

The present work represents the seventh edition of this excellent book on Emergency Surgery. This is undoubtedly the finest book available on Emergency Surgery.

The book is extremely practical and the assumption is made that a young surgeon is dealing with a patient stricken with an acute surgical emergency. The problems are discussed from the standpoint of the isolated, young and capable surgeon called upon to carry out appropriate treatment under these conditions. Emphasis is placed on when to operate, when not to operate, and how to operate under emergency situations. Many authors contributed to the revision of chapters, correction of portions of chapters, and writing of some chapters, but the work is obviously the masterpiece of Hamilton Bailey who has devoted his life to making this the outstanding text on Emergency Surgery. I think he has completely succeeded in this and the book is highly recommended to general surgeons.

The topics covered include: The Extremities; Ear, Nose and Throat; Abdominal and Thoracic Surgery; Urological Surgery; Proctological Surgery; and Congenital Anomalies. The lesions are discussed in sufficient detail, and great emphasis is placed on the unusual conditions in which emergency surgery is a life-saving procedure. Some objection might be raised to the space devoted to these rare conditions, but when one is dealing with an individual life, sufficient information about an individual problem must be available to the surgeon confronted with emergencies to solve these problems. This is the spirit in which the book is written and it succeeds entirely.

This book is wholeheartedly recommended as an outstanding text on Emergency Surgery.

Victor Richards, M.D.

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DISEASES OF THE COLON AND ANORECTUM—Volumes 1 and 2—Edited by Robert Turell, M.D., Associate Surgeon and Chief, Rectal Clinic, The Mount Sinai and Montefiore Hospitals; Surgeon, Bronx Municipal Hospital Center; Associate Professor of Clinical Surgery, Albert Einstein College of Medicine, New York. W. B. Saunders Company, Philadelphia, 1959. Vol. I, pp. 1 through 608; Vol. II, pp. 609 through 1238. $35.00 per set.

This is a massive, complete work in two volumes of diseases of the colon and anorectum. Altogether there are 1238 pages in the two volumes at a price of $35.00 per set. The two volumes have been edited by Robert Turell, M.D., a well-known proctologist, and consists of some 50 odd chapters, the majority of the chapters being written by separate individuals. Everything is covered from chronic constipation to diets to pruritis ani to sphincter-saving operations. The contributors have been carefully selected for their actual contributions to surgical literature in the chapters that they have written. The organization of the book is: Applied Basic Science, 10 chapters; Diagnosis, 4 chapters; Anesthesia, 1 chapter; Colorectal Lesions, 25 chapters; Anorectal Lesions, 8 chapters, and 10 chapters on special considerations in diseases of the colon, anus and rectum consisting of Congenital Anomalies, Pediatric Problems, Obstetrical and Gynecological Problems, Complicated Problems in Malignancy, Office Problems, and Occupational Aspects of Anorectal Disease.

The book is profusely illustrated. The drawings are clear and accurate, and the techniques illustrated are those that have proved successful in the hands of the contributors.

The book is directed primarily to the general surgeon, but it would serve equally well for specialists in proctology as a reference book. It is quite complete, the newest concepts have been presented, and since a large variety of authors is included in the various chapters there is no dominance of the book by personal impressions of the editor. Each chapter has been preserved as an independent whole, but the chapters together are arranged into a complete coverage of ano-rectal and colonic diseases for gastroenterologist, internist, pediatrician, or general practitioner. The book, I think, will be particularly helpful to the general surgeons who are interested in a good reference book on diseases of the colon and anorectum and a quick method of finding the solution to the immediate problem at hand.

The only objections that I have to the book are that it is too lengthy and too costly, but an effort has been made to make it comprehensive.

Victor Richards, M.D.